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ABSTRACT

Increased attention to adolescent health and well-being has been stimulated by rising mortality rates and high morbidity rates among adolescents. Several national inquiries have found that the responses of medical and other service systems do not adequately meet the health-related needs of adolescents and that a different approach, involving collaboration among the various service sectors that impinge on adolescents' lives, is needed. The school is being viewed as the hub around which these services can most easily and effectively be coordinated and delivered to teens. This school-linked, multi-service model has been implemented in a number of states. Initiatives in California, Florida, Kentucky, Michigan, New Jersey, New York, and Oregon are outlined in this report. Highlights of a seminar that focused on the many interrelated health problems of adolescents open the report. In addition, the report reviews research related to adolescents' health status; reviews the influence of changing family trends and the role of parents in promoting well-being; discusses the shortcomings of the current health care system with regard to adolescent health needs; discusses how to make services "family-friendly"; describes the background, history, and key components of school-linked, multi-service demonstration programs; and identifies issues about school-linked centers that need further study. (IAH)

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PROMOTING ADOLESCENT HEALTH AND WELL-BEING THROUGH SCHOOL-LINKED, MULTI-SERVICE, FAMILY-FRIENDLY PROGRAMS

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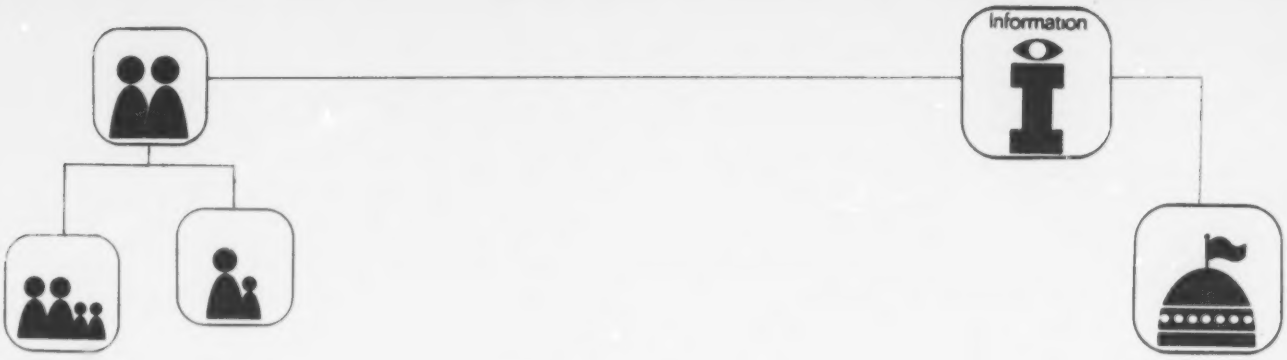

PROMOTING ADOLESCENT HEALTH AND WELL-BEING THROUGH SCHOOL-LINKED, MULTI-SERVICE, FAMILY-FRIENDLY PROGRAMS

July 12, 1991, Mansfield Room (S.207), U.S. Capitol

Panelists: **Denise Dougherty**, director, Office of Technology Assessment study on Adolescent Health
Joy Dryfoos, independent researcher and professor at Columbia School of Public Health
Leslie Hodes, director, South Brunswick, NJ School Based Youth Services Program
Howard Weiss, director, Family-School Collaboration Project, Ackerman Institute, New York, NY

Moderator: **Theodora Ooms**, director, Family Impact Seminar

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Promoting Adolescent Health and Well-Being Through School-Linked, Multi-Service, Family-Friendly Programs

Background Briefing Report
and Meeting Highlights
by
Theodora Ooms
and
Todd Owen

This policy seminar is one in a series of monthly seminars for policy staff titled, *Family Centered Social Policy: The Emerging Agenda*, conducted by the **Family Impact Seminar**, American Association for Marriage and Family Therapy, Research and Education Foundation, 1100 Seventeenth Street, N.W., The Tenth Floor, Washington, D.C. 20036, 202/467-5114.

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PROMOTING ADOLESCENT HEALTH AND WELL-BEING THROUGH SCHOOL-LINKED, MULTI-SERVICE, FAMILY-FRIENDLY PROGRAMS.

Highlights of seminar meeting held on July 12, 1991, Mansfield Room, S. 207 in the U.S. Capitol. (A supplement to the background briefing report.)

This seminar focuses on the many, interrelated health problems of adolescents which are at last receiving national attention, said **Theodora Ooms**, the moderator, in opening the program. A decade ago teenage pregnancy was the only adolescent issue policymakers seemed concerned about. She found it encouraging that the reports of several new broad based inquiries into adolescent health concur on the nature and scope of the problems and also on the promise of emerging school-linked initiatives.

The first speaker, **Denise Dougherty**, was introduced as the director of the congressionally mandated, two-year, Office of Technology Assessment (OTA) study on adolescent health which has just released its final report. Dougherty began by saying the three volume report finds the conventional wisdom that "adolescents are so healthy they don't need health services" is not true. This false impression may be one reason adolescents have not had much access to services. Importantly, the report concludes that adolescents clearly need services but there are many barriers to their receiving them. The first type of barrier is financial. One in seven adolescents have no health insurance. One in five are poor and of these one in three do not have access to Medicaid. Even those with insurance often do not have coverage for the type of services adolescents most often need, such as prevention or mental health services.

Dougherty said that there are also a number of barriers specific to all adolescents regardless of race/ethnicity or socioeconomic status. They typically have no independent sources of income. Because of their lack of experience and because little information about the availability of health services is provided to them, adolescents are much less knowledgeable than most adults about when and where to go for health services. Requirements for consent and confidentiality vary widely by state, age, and type of services received. There is a scarcity of trained providers who know how to work with adolescents. And there is very little federal support for training; the Maternal and Child Health Bureau funds only six federally sponsored, interdisciplinary training programs in adolescent medicine.

The OTA report outlines a number of possible options for overcoming these barriers. Dougherty enumerated several of these and said that school-based or school-linked health centers were judged to be a most promising option for increasing adolescents' access to health services. This is primarily because schools are where most adolescents can be found. The centers offer confidential services (after parental consent is obtained) either in or near schools or by referral.

Dougherty then referred to data from four Center for Population Options (CPO) surveys of school-based clinics on the clinics' sources of funding. (School-linked centers were not surveyed.) In the 1988-89 school year, public funds accounted for 70% of the funding. Federal funds through Title V block grants and Medicaid comprised 17%. States, cities, counties, school districts, and community health centers combined accounted for 53% of the funding. Foundation grants supplied 26% of their funding (see p. 37, Table 15-14 from the OTA Report, Vol. III).

In the past, foundations were key to getting a school-linked health center started but states are now providing an increasing amount of funds. As of now, there is no direct source of federal support for school-linked health centers. The OTA report suggests that Congress could enact legislation to help provide seed money. There are currently two Senate bills that would provide some support for school-linked health centers (see p. 21) although, Dougherty said, some on Capitol Hill feel this is a local not a federal issue.

One in Four Teens At Risk

The second panelist, **Joy Dryfoos,** is an independent researcher and professor at Columbia School of Public Health and author of the new book, *Adolescents at Risk: Prevalence and Prevention.* She presented the concept of teenagers "at risk."

In her own youth, "our major worries were about acne and chubbiness." Today, Dryfoos said, adolescents' health is measured by the extent of their involvement with sex, drugs, violence, depression, and stress. A small number of teens "do it all." She estimates that 10% of the 10-17 year old population engage in multiple behaviors like substance abuse, early delinquency, unprotected sex, and truancy from school and are at serious risk of damaging themselves and others. Another 15% are on the verge of being at serious risk. This means that 7 million kids (i.e. one in four) are at risk of never growing up to be responsible adults. Additionally, there are another 25% who experiment in these areas and are at some risk. However, Dryfoos added,"The good news is that about half are doing O.K. They may have some difficult times, but with caring and support they come out all right."

Dryfoos cited some of the common characteristics of high-risk youth as including; early initiation of high-risk behavior, trouble in school, lack of parental support, lack of resistance to peers, living in disadvantaged neighborhoods, depression, and stress. "These aren't just urban black kids," Dryfoos said, "suburban and rural areas have disadvantaged neighborhoods and those white youth are in as much trouble as their black and Hispanic peers." Trouble in school, specifically being two years behind in school is a very strong predictor of engaging in other damaging behaviors.

"One in four high-risk kids will need massive interventions to rescue them," according to Dryfoos. "And while there is no simple way to help, you cannot separate the solution to kids' problem behaviors and the problems of the educational system. They are intertwined."

Programs That Work

There are some very good ideas about what to do. In her book Dryfoos identifies 100 quality demonstration programs which are successful because "they address the predictors of problem behaviors not just the individual symptoms of the larger problem." These diverse prevention programs have a number of common components.

---One-on-one individual attention. Programmatically, when a responsible adult is attached to a disadvantaged child the child does much better. Dryfoos said she would turn this into a law requiring that every child must be attached to a responsible adult, if not the parent, then to someone else. This must occur early in the child's life. Dryfoos calls this the "Sherpa Solution."

---School-based. Most of the prevention programs were located in schools but they were not run by the schools. Community agencies provided the services with outside funding.

---Community-wide, multi-agency, multi-component programs. Schools realize that they can't be the surrogate parents and deal with all the problems of high-risk children. Schools are desperate for help to deliver needed services, services which are currently fragmented and, as a result, not very effective. There are no single miracle programs which can be dropped into the community and be successful overnight. The successful programs are complex arrangements that include many components and must be established cooperatively with parents, professionals, and community leaders. Planning such programs take a great deal of time and patience.

Dryfoos said she had a vision of new institutions---"community-schools"---which would combine quality education with quality services in one location. This is happening in numerous states and communities. Communities need seed money to get started because "nobody gets up in the morning and says let's collaborate!"

Dryfoos summarized her remarks by saying "one-quarter of the kids in this country are going down the drain. I would call this a disaster of unprecedented dimensions." She said we should concentrate on using schools as the location for service delivery. Some existing resources could be used in new ways---Chapter I programs and substance abuse and AIDS prevention monies, for example, could be spent to support these centers. And high priority should be given to helping communities and schools put the needed pieces together to "develop a more rational and caring institutional entity."

Family-sensitive, School-linked Programs

Leslie Hodes, director of the South Brunswick (NJ) School-Based Youth Services Program (SBYSP) spoke next. Hodes commented that no matter where you live, even in her suburban setting, teenagers today experience a wide range of problems. She was amazed at the depth of their students' problems including depression, sexual abuse, substance abuse, and other serious dysfunction in the family.

But the first, most important lesson they have learned is that teens are not embarrassed or humiliated to be seen accessing mental health services. They will talk to adults whom they trust and who are consistently there for them. The second lesson they learned is that kids will talk with their parents. First, they typically say, "Oh no, my parents will never understand." And we say, "We'll teach your parents and you how to talk with each other about this." They are O.K. with this, mostly very relieved.

Hodes said that there are 29 school-based sites in New Jersey, most of which are rural or urban and a few are suburban. Each is uniquely geared to the needs of the community it represents. (For a description of the state program see page 30.) For some communities which are really spread out, like the mixed income, ethnically diverse South Brunswick, transportation is a major issue. In her community the teens had nowhere to meet so one of the first things they did was to establish a recreational teen center. The teen center planning board has been the nucleus of activity for the school-based center. The teens make the rules, decisions, and plan activities for the center.

Hodes stated that successful programs in New Jersey have accomplished several important things. They have integrated services into an existing school structure. They provide a preventative-wellness model developed for all kids, not just severely dysfunctional or high-risk kids. And they provide supportive, trustworthy adults for teens to talk to.

Hodes then referred to a handout which detailed the organizational structure of the South Brunswick program. The SBYSP was established through a yearly, $170,000 grant from the

New Jersey Department of Human Services and is operated by the University of Medicine and Dentistry of New Jersey's Community Mental Health Center at Piscataway, in cooperation with the South Brunswick Board of Education. This grant pays all the salaries and teen center supplies. The Board of Education supplies $53,000 of in-kind support. In addition, Hodes said she has raised support for special projects from the business community. According to Hodes, the most important aspect of their structure is that the non-profit lead agency, the Mental Health Center, and the School Board of Education are willing to collaborate and work with each other to support the teens they represent.

The program is guided by an advisory board, comprised of parents, community members, students, and agency representatives, which meets monthly and brings ideas to the governing board. Within the program the school guidance counselors and teachers in the school know and are comfortable with the nurse, mental health counselors, and other service providers staffing the program. "One of the beauties of our program is the ease with which staff make internal referrals." According to Hodes, this trust and communication between staff of the school and the SBYSP staff has made a world of difference in the successful implementation of this program. Hodes then discussed some of the program's components.

She began with the mental health services which are such a strong component of the program overall and take a family systems approach. Therapists, especially trained in family therapy, work hard with teens to include significant family members in some of their discussions and they try to see parents as allies rather than adversaries. They have two full-time and one part-time therapist. On a monthly basis they see 75 individual kids and at night 10-15 families. The therapy lasts on average three to six months. Sometimes longer, but if a kid has serious problems he/she may be referred to somewhere outside the school.

Teens and their parents often go through really difficult periods of confusion and turmoil, explained Hodes. The program staff teach families coping mechanisms and give them support to deal with these difficult times. The staff generally don't treat severely mentally ill teens, however, it may take a lot of work with them and their families for them to agree to go outside for more specialized assistance.

These services are available during the day and evening and in the summer. Among the other services offered within the program are:

---An employment counselor helps with job search strategies and resume and interview preparation.
---A cross-age peer tutorial program trains high schoolers to be mentors for elementary and junior high schoolers (funded by a corporation).
---A nurse/educator helps with problems such as sexuality, bulimia, anorexia, diet, and nutrition.

The teen center, which is open three nights a week during the summer and two afternoons a week after school, offers special interest groups, recreational activities, tutoring, SAT preparation, and informal counseling. It also offers a different food or craft activity each night which brings together kids from various groups who would not otherwise socialize with each other.

New Jersey is starting to do an evaluation of the impact of its school-based centers on dropout rates, school achievement, and other indicators.

The final speaker was **Howard Weiss**, a psychologist and family therapist. Weiss directs the Family-School Collaboration Project at the Ackerman Institute for Family Therapy in New York

City. Weiss said that it is important to create a climate of collaboration so that families are active partners, not only in the creation of these programs, but in their ongoing functioning as well.

Weiss pointed out that collaboration can mean two different things. One definition is that collaboration is an on-going process of communication and problem solving, creation of a common set of goals, and negotiation of any difficulties. The second is doing these things "with the enemy," as in wartime! This, Weiss said, is a key issue for implementing the concept of school-based programs, especially in the most at-risk neighborhoods because families, schools, and agencies have often been alienated from one another, if not adversaries.

Weiss stressed that we have to watch out that our implicit assumption is not that "we are liberating children from their bad families." Unfortunately this was the underlying premise of some of the early prototypes of comprehensive services for youth. When we provide a whole range of services because they are not being provided by parents we have to be aware we may give an implicit "blaming" message to parents.

In accomplishing family-centered, school-based programs we have to establish the preconditions for positive relationships in a host of concrete ways. This can be a challenge because in many cases the assumption of an adversarial relationship between the family and school is held by both parties. (When a call comes from the school, the family's first assumption is that it is "bad news.") Indeed, the most important barrier in connecting with parents is that parents feel that they are being blamed. Similarly, educators feel that if the parents are coming in to the school on their own initiative it must be to blame someone at the school.

Creating a climate of collaboration

Weiss reiterated that we want to establish a climate of partnership where people are involved in a collaborative set of activities, working toward a common set of goals, where parents repeatedly experience that the way we do business is to collaborate with them.

Weiss then gave some concrete examples, beginning with how schools communicate with families. Most letters from school are versions of "we regret to inform you that...." Instead, all letters and materials sent out from school should signal that collaboration is the way the school does business. Most permission and consent forms are written in a way that signal to parents "sign for this and then let go and get out of the way." But these same forms can be rewritten to emphasize that this is the beginning of a continuing collaborative relationship. Families respond positively to this type of invitation.

In a similar vein, schools are always talking about how they cannot get families to come in, and especially that fathers will not come in. But in Weiss' view, "it would make good sense to refuse most invitations." When instead, we write to invite them to share their strengths, knowledge of their kids, and their hopes for them we then have a basis on which we can work together.

Family-School Forums

Weiss added that we also need to establish contexts and concrete processes which create a climate for fostering development of authoritative parenting and interaction between young people and adults. In the project staff's work with schools they have created a series of Family-School Forums which bring together students, parents, and school staff to discuss problems, issues, and ideas. The staff also create activities (climate-building activities) which provide opportunities for students, parents, and staff to collaborate in learning, planning, and problem-solving experiences.

One parent had told Weiss that she knew she was tremendously intrusive in her son's life. She felt that she didn't have enough of a "window" on the things going on in his life to know if she could feel safe about the values he and kids his age had or the choices they would make. Participation in the Family School Forum became for her, and many other parents, a "window" on their teens' lives.

At the Forums parents say they see and hear their own kids behaving in ways they didn't think possible: functioning like a responsible adult, having the respect of adults and students. That is an important thing for parents to see. Or they see other parents and children interacting in ways their family could act but do not. These meetings create a tremendous multiplier effect.

Of course, Weiss continued, there need to be boundaries between parents and teens but there also must be a context for active negotiation of these boundaries. In order for youth to have a good separation, they need to have a good attachment. "We should all be trying to help youth move from dependence to interdependence, not independence."

The Family-School Collaboration Project is working on ways to build into orientations and family-school meetings experiences which enhance and reinforce collaboration. Weiss said that project staff had worked intensively in five different school districts and conducted brief training workshops in a total of sixteen districts over the past eleven years in New York City.

According to Weiss, we need to look at how we do what we already do. In the schools his staff have been in they have identified anywhere from 5-12 separate prevention programs in one school, "stacked like chips," not connected, and aimed essentially at the same kids. Few of these programs involve families. While we spend billions on education and at-risk prevention, we don't bring the family and school, the two major systems involved in children's socialization, together in a collaborative way in any of these efforts. "All these families care about their children. Only a very few families are too disturbed to not care, let's not build our programs solely around them (which is what we do at present)."

In summary, Weiss said that it is important to keep in mind that schools are more than just the convenient physical location for service delivery. We must build relationships between the school, agencies, parents, and kids. According to Weiss this takes time, it can take two to three years in a school or school districts to achieve such collaboration. But it can be done.

Points Made During The Discussion

- In response to Weiss' comments about creating caring, collaborative contexts, Dougherty noted that the OTA report begins by saying that the most important goal is to try to create a more sympathetic and supportive environment for adolescents. This cannot be legislated so the question is how can this quality be built into programs.

- Weiss said that while it is difficult, you can legislate such things as requiring collaboration and coordination. It would be intriguing to see what would happen. But you must be careful about what the target is because collaboration and cooperation can have very different meanings. Also, when we focus on planning evaluations we must look at not only the numbers of clients served but also ask how the clients themselves assess the services and outcomes.

- A participant from the Office of Population Affairs asked Dryfoos whether, given the overlap between so many discrete prevention programs and the lack of integrated services in the

community for adolescents and children, "do you see the need for case managers at the school site to broker and coordinate what the kids need, particularly for the 25% high-risk group?"

"Absolutely," Dryfoos responded. She then mentioned a sophisticated model in development in San Diego, the New Beginnings project, where they are building a center next to the school. It is a collaborative project aiming to bring all the caseworkers serving the families in the community into a central location. This center will be used as an entry point into the school system so that kids and families have a good idea of what services are being offered.

Dryfoos also agreed that she thinks it is very important for some kids to be attached to a responsible adult in some formalized way but it doesn't have to be "case management." A lot of wonderful mentoring programs fall apart because they are not formalized. Ideally it would be a highly trained community person who is part of the system as a paid full-time employee.

- A participant from the National Association of State Boards of Education (NASBE) said that a lot of schools seem to think that kids will learn only if we can take care of the "baggage" kids bring with them to school. She asked, "Do you see any movement towards the realization that schools themselves have got to alter their organization and instruction in order to create engaging places for kids to learn and develop?"

  Weiss responded that the Family-School Collaboration Project pays a lot of attention to this issue and overcoming the implicit and explicit blaming that goes on is critical. This requires principals who are willing to move towards creating a different environment in the school. The leverage that comes from connecting families and school creates a willingness to change. "I think the kiss of death is when it is imposed from the top down. It has to happen from the bottom up and the top down simultaneously."

- A participant from the Family Research Council was concerned about reports her organization had been getting on school-based clinics that apparently used parental consent forms as a way of getting around involving parents in the dispensing of contraceptives and abortion services.

  Dryfoos felt that these reports were based more on opinion than fact. Her reading of the research was that when consulted, parents do want their teens to get help with these issues. She pointed out that the percentage of school-based clinics that dispense contraceptives appears to be shrinking and that those that do require parental consent. Research shows that the distribution of contraceptives does not increase the level of sexual activity in that district. Research also shows that close to 100% of parents sign consent forms.

  Very recently, in a Baltimore community where clinics had not distributed contraceptives in their first five years, parents who had signed consent forms (97%) were surveyed to see if they desired a change in this policy. Of those responding, 93% said as long as there was parental consent they wanted their kids to be able to get contraceptives in the schools.

  Hodes added that in New Jersey, informed parental consent is an essential part of the program. The consent form lists the available services and allows parents to consent to some or all of the services. And while they do offer contraceptive counseling, there is no dissemination of contraceptives in the New Jersey program.

  Dougherty mentioned that some states do have laws which allow schools to distribute contraceptives or provide contraceptive counseling without parental consent. If people don't like these policies it is an issue to be taken up with the state legislatures but school-linked health centers do not appear to be doing anything not allowed by law.

- A participant from the Robert Wood Johnson Foundation School-Based Adolescent Health Care Program noted that they work with 18 funded programs that include 24 school-based health centers. A few communities had expressed some initial reservations about these centers, but after four years they haven't received a single letter registering concern about what was happening at the health centers.

- Hodes was asked by someone from the Infant Mortality Commission about what variables were used to determine both service need and outcomes and if she had been able to quantify the connection between clinic services and this success.

  Hodes responded that New Jersey is working with Johns Hopkins University to create some outcome measures. She also noted that their program is still in the early stages and they are in no rush to begin the evaluation process. They are more interested in developing the individual programs. However, in her program, they have been working to develop a few evaluation pieces. In the last year, just within the mental health component, each student is given two inventories upon intake and again at the completion of counseling. One is a Cowpersmith test for self-esteem and the other is a Brief Symptom Inventory to measure decreases in symptoms. It is too early to have any results from the use of these evaluation tools.

  Weiss stated that the desired outcomes should be clear. School-based health centers ultimately aim to affect academic achievement, reduction in dropouts, and increases in attendance. These are all good measures, as well as a reduction of high-risk behaviors. "If we want to connect service delivery with teachers and parents then the key outcome is whether we are making the child more successful (on all these dimensions)."

  Dougherty said we should keep in mind that, for the most part, these centers are not providing new services that have never been evaluated. They are making basic services, which have already been proven effective, more readily available. Whether the school-linked centers are doing this effectively or how school-linked centers vary amongst themselves is another issue that deserves research.

- A gentleman from the National Puerto Rican Coalition asked Howard Weiss what percentage of kids in his programs were from families headed by single women? What problems did these kids bring to the program and what approaches were used to deal with these families? He also mentioned that the Hispanic population in New York City is very distrustful toward any state-run institution such as schools. What things need to be done to address the issue of this population's distrust?

  Hodes said that 50% of the kids in the schools in their program are from single-parent families. One example of what they do is they set up a support group at night and in one room counselors worked with the kids and in another room mothers received a variety of counseling.

  Weiss said their project began in predominantly Hispanic East Harlem. He noted that while single-parent families are not a homogeneous group, they do have special needs. In Hispanic families there are usually other adults in the picture (e.g. grandparents). This requires training for work with families and cultural sensitivity on the part of the educators.

  There are important factors in establishing trust. Does the school offer pathways for the families' success and advancement as parents, workers, etc.? Do the parents see that teachers and other school personnel care for their children? Do they feel that if you have a concern about their children that you will let them know? If the answer to these is yes, Weiss said, they have found that Hispanic parents will feel comfortable with the program and the school.

PROMOTING ADOLESCENT HEALTH AND WELL-BEING THROUGH SCHOOL-LINKED, MULTI-SERVICE, FAMILY-FRIENDLY PROGRAMS

INTRODUCTION

After decades of neglect, adolescent health and well-being are now receiving a great deal of public attention. Concern is focused on high and rising mortality rates especially among older teens and continuing high rates at all ages of what are being called the "new morbidities"---accidental injuries, substance abuse, sexually transmitted diseases (including AIDS), teen pregnancy, sexual and physical abuse, depression, and suicide. Further, there is a growing awareness of the serious consequences of these problems for the spheres of school, work, and family.

Several recent national inquiries into the status of adolescent health conclude that the current responses of the medical and other service systems fall far short of meeting teenagers' health-related needs. Increasingly, it is acknowledged that efforts to promote adolescent health and treat health-related problems require radically different approaches involving closer collaboration at the community level between the various service sectors that impinge on adolescents' lives.

The school is being viewed as the hub around which these services can most easily be coordinated and effectively reach teenagers. Current estimates are that there are around 300 programs across the nation established to provide a range of health-related services to teens located either in or near schools. This school-linked, multi-service model is moving beyond the demonstration phase to being replicated statewide in a number of states---most notably in Florida, Kentucky, Michigan, New Jersey, New York, and Oregon. Important legislation providing substantial funds for a 100 new programs was enacted last year in California, and at least two bills are pending in the U.S. Congress to provide direct federal support.

In this background briefing report, we:

- Review the research related to adolescents' health status, drawing on several recent major publications, synthesizing the studies, and assessing the adequacy of the health care system's response.
- Review the influence of changing family trends upon adolescents' health and the role of parents in promoting their well-being.
- Discuss the major shortcomings of the present health care system's response to adolescent's health needs and how services can be "family-friendly" within the context of protecting confidentiality.
- Describe the background, history, and key components of school-linked, multi-service demonstration programs which address many of these key barriers.
- Identify some of the questions and issues about school-linked centers that need further study and debate especially the critical issue of federal and state roles in financing these services.
- Briefly summarize the school-linked services initiatives in several states; list key organizational resources and selected references.

WHAT DO WE KNOW ABOUT HOW HEALTHY ADOLESCENTS ARE?

(Sources: AMA, 1991; Dryfoos, 1991; Gans *et al.*, 1990; Irwin, *et al.*, 1991, Millstein and Litt, 1990; National Association for State Boards of Education, 1990; Spencer and Dornbusch, 1990; U.S. Congress, Office of Technology Assessment, Vol. I, 1991)

Note: One of the problems that plagues the field of adolescence in general is that studies, agencies, and organizations use different age spans to define adolescence. For example, among the major new reports on adolescent health drawn on for this report the Office of Technology Assessment study in general focuses its analysis on school age adolescents ages 10 through 18. So does the NASBE/AMA Code Blue report and the Dryfoos book. However, many of the studies they cite report on data through age 19 or older as does one of the AMA's series of reports, Profiles on Adolescent Health. And the AMA's compilation of adolescent health objectives from the Healthy People 2000 national objectives, focuses on ages 10-24 years, thus including young adults in its definition of adolescents.

Data Sources and Limitations

How good is the information available on adolescent health? The Office of Technology Assessment (OTA) has recently completed a congressionally mandated two-year study to review current knowledge related to the physical, emotional, and behavioral health status of contemporary American adolescents. The study was requested to focus special attention on adolescents living in poverty and rural areas and those from racial and ethnic minorities. The findings are presented in a three volume report (U.S. Congress, 1991). In an appendix to Volume I, and at many points in the text, comments are made about the many problems with the data and research currently available about adolescents which seriously constrained and frustrated the OTA study. Among the major problems cited are the following.

---Current national data reflect very limited conceptualizations of health. The indicators available are typically disease-focused. The most frequent outcome indicators used to assess health and well-being are physician visits and mortality due to natural causes. These measures fail to capture the realities of adolescents' health status and behavior and undercount the severity of their problems and unmet needs for services.

---Data collection efforts are fragmented and uncoordinated. OTA's report lists about 60 different U.S. executive branch agencies with some role in adolescent health. Many of these collect some data related to adolescent health but there is little coordination between them. A particular problem from the policy perspective is that information on health status is rarely collected along with income data. This frustrates efforts to disaggregate differences in teen's health status associated with race and ethnicity from differences associated with income. Only one major health survey collects income along with health data, the National Health Interview Survey. Similarly, surveys that focus on one health problem---such as teen drug use---seldom collect information on other problems---such as teen pregnancy (GAO, 1991).

---It is very difficult to find out how many teens are served by public programs. Most published health and program data lumps all children together and do not publish data by year of age. When they do report on teens separately they use different age groupings to define adolescence making comparisons between studies difficult or impossible.

---The report notes many gaps in existing data and research on adolescence, most of which have focused on a limited number of health problems. Moreover, it is difficult to ascertain the proportion of federally funded studies on child health which have focused on adolescence. As

one example, between 1980 and 1990 the proportion of the National Institute on Child Health and Development's budget that was spent on adolescent research was only 7% and most of these studies were related to teen pregnancy and sexual activity. In recent years, the National Institute for Drug Abuse has conducted regular surveys related to adolescent substance abuse. However, many health issues have been ignored and there is almost no data available on adolescents' use of health services, especially from adolescents themselves.

Some important efforts are already underway to improve the quantity, quality, and utility of adolescent data and research. For example, the National Academy of Sciences, Panel on High Risk Youth, is conducting an in-depth examination of the state of research and program experience concerning high-risk youth. The National Institute for Child Health and Development is planning to begin a new research initiative on adolescents.

Most importantly, in 1988, the Center for Disease Control (CDC) established a Division of Adolescent and School Health to serve four functions. These functions include identifying and monitoring the incidence and prevalence of the most significant health risks among youth. After extensive planning and consultation in the development of the questionnaire, the CDC launched the **Youth Risk Behavior Surveillance System** (YRBSS) to collect self-report data from youth on a range of risk behaviors, with an emphasis on HIV-infection risk factors. The survey will be conducted at the national level on a national probability sample of high school students every other year. In addition, the YRBSS instrument will be added as a supplement to the National Health Interview Household Survey in 1992. Arrangements are being made with states to use the YRBSS periodically to assess risk behaviors on a statewide basis (Kolbe, 1990).

The exciting potential of this survey system is that for the first time it will be possible to correlate risk behaviors on a national basis. Eleven reports from the 1990 survey have already been published. Thus far each has only reported on a single risk behavior, but there are plans to do correlational analyses across behavior categories in the near future (Center for Disease Control 1991-92).

Adolescents' Health Status

In terms of the standard medical criteria, adolescence still remains a relatively healthy time of life. Teenagers have the lowest overall death rates of any age group and are less likely to experience serious disease and chronic illness, spend less time in hospital or at home sick, and are more likely to be assessed in excellent or good health than adults.

In some important respects teen health has improved over previous decades. Deaths from natural causes (i.e. related to disease) have dropped steadily and children with seriously disabling conditions are much more likely to live to adulthood. In addition, there has been a decline in some teen health damaging behaviors such as alcohol-related traffic fatalities, and use of some illicit drugs, and, most recently, an improvement in condom use.

What then accounts for the current intense concern about the status of adolescent health? The NASBE/AMA *Code Blue* report identifies the "current crisis in adolescent health." The OTA report suggests that "perhaps one out of five of today's 31 million adolescents have at least one serious health problem.....and often face formidable barriers in trying to obtain basic health care" (OTA, 1991, p. 1). The AMA report states, "Today's adolescents experience health problems that threaten not only their current health but also their ability to become healthy adults capable of leading full, productive lives" (Gans et al., 1990, p. 4).

Several major conclusions about adolescents' health are gaining wide acceptance and leading to a rethinking of the current patterns and systems of health related services. Some of these major findings are the following.

- *At the root of much of the concern is what is known as the "new morbidities"---high rates of accidental and violent deaths, accidental injuries, substance abuse, teen pregnancy, sexually transmitted diseases, depression, and so forth.* The majority of adolescent deaths, injuries, and health problems arise not from disease, as is the case with children and adults. They arise from behavioral, social, and environmental causes that are largely, in theory at least, preventable. The leading cause of adolescent death and injury, for example, is vehicle-related accidents. This is followed by suicide and homicide, whose rates have increased dramatically among both older and younger teens over the past twenty years. (In fact, in the seventies adolescents were the only age group whose mortality rates were rising.) These new "morbidities" are highly related to behaviors such as teen sexual activity, alcohol and other drug use, and parental physical and sexual abuse.

- *There are some significant gender, racial/ethnic, and income differences in adolescent health indicators that have important policy and program implications.* For example: black male mortality rates are 30% higher than white males, and black male homicide rates are five to six times higher than white male rates. Yet white males are more likely to die from motor vehicle accidents and suicide. Whites are more likely than minority youth to experiment with alcohol, drugs, and tobacco and to be heavy users of all harmful substances except alcohol. Mexican Americans and black females have high rates of obesity. Asian American teens are less likely to become pregnant but Asian refugees are more likely to be depressed and have tuberculosis. Native Americans have poorer health on almost every dimension and are at especially high risk of being born with fetal alcohol syndrome.

  Eating disorders are more common among females than males and occur more frequently among middle- and upper-income youth. And importantly, overall, adolescents of low income are at much higher risk of being generally in poor health and having limitations due to a chronic condition.

- *Conceptions of adolescent health must be broadened to include psychological and emotional well-being and the connections between them.* When adolescents themselves are surveyed, mental health problems, including family problems, rank high among their lists of concerns and mental disorders are the leading cause of disability leading to limitations in activity in adolescents. There is a growing acknowledgement that many adolescents may go through periods of transient emotional stress and difficulty that can be quite acute and cause serious, albeit temporary dysfunction. In addition, rising numbers of teens experience more serious, long-lived disorders such as depression leading to suicidal thoughts and actions. From 8-13% of adolescents report having attempted suicide. And this age often sees the onset of social phobias, schizophrenia, and acute anxiety disorders.

- While teens from every social, racial, and economic group have health problems, *certain sub-groups in society are at highest risk of health-related problems, especially the poor and minorities.* These groups are less likely to succeed in school, may fall behind several grades, drop out of school, and will consequently have much difficulty obtaining jobs and performing as a responsible adult. These groups also have the least access to health care treatment and preventive services.

- *Service systems and preventive programs are usually ineffectively targeted on only one type of problem behavior.* Yet, health damaging behaviors are frequently linked in a variety of ways and many teens engage in more than one, or in multiple, problem behaviors.

Overlap between problem behaviors

Joy Dryfoos, who investigated research on the four behaviors most associated with being "high risk"---delinquency, substance abuse, teen pregnancy, and school failure---was the first to estimate the extent of overlap between them on a national basis. In her book, Dryfoos identified several common characteristics---risk factors---that predict these four problem behaviors. These were early initiation of the behavior, peer involvement, ineffective parenting, poor neighborhood quality, and early school failure (Dryfoos, 1991 b). She points out that researchers are only just beginning to investigate "resilient" children, that is, those teens who overcome risk factors, succeed in school, and avoid serious problems. Available data suggest that these "invulnerable" children invariably have the support of a responsible adult.

When reviewing the research she found that no national survey to date had investigated the proportion of teens who are simultaneously, and continuously engaged in several risk behaviors as compared with those who do only one or some, and only occasionally. Nor do the studies of co-variance relate these problem behaviors to general health or emotional status. Dryfoos reviews the few studies that ask about more than one of these behaviors and concludes that in the aggregate they confirm the hypothesis that problem behaviors are indeed interrelated. Nevertheless, we know little about the causal relationship or sequencing of these behaviors.

In the absence of any national studies investigating co-variance, Dryfoos then synthesized and aggregated the results of existing studies. She chose studies that focused on the four problem behaviors and developed a rough estimate of the national proportions of 10-17 year olds that fall into each as follows:

---10% (about 3 million) engage persistently in multiple problem behaviors and are at very high risk . They are delinquent, engage in unprotected sex, abuse substances, and are failing in school.

---15% (about 4 million) are at high risk and participate in many of the same behaviors but with less frequency and consequently with less serious consequences.

---25% (about 7 million) are at moderate risk. They are experimenters and at any one time are usually involved in only one of these behaviors.

---50% (about 14 million) are in the low-risk category. They do not commit any serious delinquent acts, do not abuse substances at all (though they may experiment with them), and are not yet sexually active.

It appears that the highest risk youth are more likely to be male, live in cities, and be poor. And minority youth are overrepresented in the highest risk group.

In addition to health indicator surveys, there is a large clinical literature documenting the confusions, uncertainties, and psychological challenges and problems young people experience throughout their adolescence. Educators and social service providers are as concerned as health care professionals about adolescents. Dryfoos says they need to be concerned because teens'

health related problems, if untreated, interfere with their capacity to complete their schooling, get jobs, and become productive members of society and responsible family members.

WHAT DO WE KNOW ABOUT THE INFLUENCE OF PARENTS ON ADOLESCENT HEALTH?

(Sources: Furstenberg, 1990; Hansell and Mechanic, forthcoming; McDaniel, et al., forthcoming; McDaniel, Seaburn, and Campbell, forthcoming; Ooms, 1990; OTA, 1991, Vol 3 Ch. 3; Small, 1990; Spenser and Dornbusch, 1990; Steinberg, 1990, Uhlenberg & Eggebeen, 1986)

Some important studies have searched for the underlying factors that may lead adolescents to engage in multiple problem behaviors. They generally concur that adolescent high-risk behaviors stem from a complex interplay of factors ranging from the personal (biological/psychological), to the social context (parents/family, peers, community) and include institutions and societal values. Thus, successful interventions need to target four different levels: the individual/psychological; family; peer/community, and environmental/societal levels. We will focus here on reviewing the research on the influence of family factors in some detail since it is not well known and has important implications for programs.

Parents are generally acknowledged to have a critically important influence on their children's lives. There is a growing body of literature on the important role of parents in adolescent development in general (for a summary see Steinberg, 1990) and of the impact of family structure on teens (see Furstenberg, 1990). And family systems literature has described the various tasks involved in renegotiating family roles and relationships during the adolescent period. However, in contrast to the voluminous studies on teenagers' health status, and on the influence of family risk factors on adolescent problems, there is a paucity of research on the role parents play in influencing their adolescents' health.

One chapter in the OTA report presents an overview of the small body of literature on the family's role. The studies that exist focus largely on the negative influence of parents. For example, there are studies that find a strong relationship between parents' smoking, drinking, and drug use and their teenagers' substance abuse. Parental depression is highly associated with adolescent depression. Parents' attitudes and behavior also appear to play a role in pregnancy and delinquency. Physical or sexual abuse inflicted by parents has been the subject of a number of studies. But there are very few studies that examine the positive roles that parents play in promoting adolescent health (see OTA, 1991, Vol II, chapter 3).

We know little about what parents' fears and worries are about their teen's health and well-being, although the clinical and popular literature suggests that they are many and often intense. Nor is there information about parents' view of the adequacy of the health care system and how it could be improved or what services they feel they need for themselves as parents of teenagers.

Individuals are seldom asked to join national advisory panels or commissions studying adolescent health to represent the parent perspective, although they do often serve on local advisory groups associated with school-based clinics. As a recent example, OTA established a panel of teens to advise the adolescent health study but did not set up a similar panel of teens' parents. (However, many of the members of the ongoing Advisory Panel, although invited in order to represent their professional or organizational expertise were in fact parents of adolescents.)

Impact of family structure and environmental context

The experience of adolescence has been profoundly shaped and changed by transformations in the American family and social and cultural values that affect and guide family behavior. Many contend that these changes---notably marital disruption, absence of fathers, and the entrance of more mothers into the labor force---are directly responsible for the rise in teen problem behaviors.(see for example, Uhlenberg and Eggebeen, 1986). Furstenberg (1990) maintains this conclusion is overly simplistic and ignores some evidence and also the contribution of other simultaneous influences. However, he highlights many family structural changes which clearly have had significance for adolescent health and well-being, although there is little research to document the kinds of effects in any detail.

---Delays in age of marriage and greater acceptability of sexual activity outside of marriage has resulted in much higher rates of unwed teen parenthood.

---High levels of divorce and remarriage are presumed to have increased stress to adolescents' lives. In 1988 only 51% of teens 15-17 were living with both biological parents compared with 62% of children ages 5-9 years (National Center for Health Statistics, 1991). In the mid-eighties it was estimated that about 11% of all adolescents lived in step-families.

---Divorce has a clear negative economic impact on mothers and children. We also now know that children suffer many short term and some long-term negative psychological effects of divorce. Some studies suggest that the trauma of divorce is hardest on younger children but teenagers have a more difficult time accepting remarriage and stepparents. (Recent studies suggest, however, that it is high levels of parental conflict, whether within or outside of marriage, which creates the stress and trauma rather than the fact of divorce itself.)

---Declining birth rates and smaller family size may have had positive effects on teen health in increasing the levels of parents' economic and psychic resources available for teens. Smaller families, however, also mean there are fewer extended family members available for support during times of stress.

---Teenagers' mothers are more likely to be employed than in previous decades. About 60% of adolescents (from two-parent and one-parent families) have mothers who are in the labor force. On the one hand, maternal employment can increase the families' income and improve the mother's sense of well-being. On the other hand, many believe that it has led to less parental supervision after school and cite studies which show that teen sex is most likely to occur in the family home in the afternoons.

---Changing relationship of fathers. Two trends pulling in opposite directions have been dubbed by Furstenberg as the "two faces of fatherhood." On the one hand, in two parent families, studies report that fathers seem somewhat more involved with their children's lives than in earlier decades (although it is not clear that this extends into adolescence). On the other hand, children/teens whose parents were never married or divorced, are much less likely to see their fathers.

Social environment. Many parents strongly believe that the world is a potentially dangerous place for teens. In the popular literature parents complain about how much harder it is to raise adolescents in today's social environment. The massive changes in social values has left them uncertain of the values they believe in since those they themselves were raised by no longer seem appropriate or relevant. Teenagers live in a world that is very unfamiliar to many parents,

presenting challenges, temptations, dangers, and experiences---especially with respect to sexual activity, AIDS, and drugs---that may be quite unfamiliar to parents and which they may be uncomfortable with. Thus, parents don't know how to provide their teens with guidance, and too often retreat from the attempt.

In addition, many parents feel that powerful forces in the environment, most notably the media but also many institutions and the peer culture, are undermining their efforts to safeguard the well-being of their teens. Finally, in part perhaps because of the "time deficit" so many of today's employed parents experience, parents today are more isolated from other parents and lack the information sharing and support their peers can provide each other. Compared to the situation facing parents with younger children, few expert sources of information, advice, or support are available for parents of teenagers.

The functions and roles of parents in promoting teen health

There are at least two factors that may explain the lack of attention to the role of parents and other family members in adolescent health. First, health care professionals, in thinking about the role of parents in adolescent health care, have tended to focus heavily on the complex and confusing issues in teenage sexual behavior, family planning, and teen pregnancy and have strongly emphasized the need for confidentiality. This has led to many public statements in which parents are viewed as barriers to needed health services and led to divisive debates about parent consent and notification. Regrettably, this issue has dominated the policy discussion to the neglect of other, vitally important roles that parents do, or could potentially, play in promoting adolescent health (see Ooms and Owen, 1990).

Second, there was a widespread belief among mental health, education, and social service professionals, fueled more by psychoanalytic theory than research, that family relationships inevitably deteriorate during adolescence, and that adolescent rebellion and conflict with parents are to be expected (Steinberg, 1990). (A correlative view is to blame parents for teenager's "bad" behavior.) Those holding this view identified adolescents' primary developmental task as being to establish their independence and autonomy and separate from their families. This paradigm shaped the majority of community-based youth service programs established in the sixties and seventies and resulted in program staff having little or no contact with youths' parents.

Steinberg (1990) reviews the studies conducted over the past decade, studies which have challenged the foundations of this paradigm. Serious storm and stress are not normative. Most teenagers do not overthrow their parents' basic values. And independence and detachment from parents should not be the goal. Those teens who remain close to and friendly with their parents do better on almost every measure. The developmental tasks of parents and adolescents then is to renegotiate and transform their relationship into one of mutual respect and interdependence.

Steinberg is careful to point out that parents should know that adolescence is **not** inherently a time of storm and stress and inevitable rebellion. This is important because belief that serious conflict is normal undoubtedly prevents many parents from seeking help earlier.

The passage through adolescence is gradual, uneven, and frequently bumpy for both teens and parents. Temporary perturbations are common, especially in early adolescence, and can be quite stressful to all concerned. (Several studies report that the typical teenager and parent quarrel about twice a week, twice as often as the typical husband and wife.) But the issues over which there is disagreement are usually minor squabbles over mundane issues. And many now believe that these kinds of conflict can be constructive, especially when the basic affectional ties remain strong.

There is no doubt that for some teenagers the conflicts with and alienation from parents become very serious and persist and the underlying affection is not present. But these seriously troubled situations are not common.

Against this backdrop of typical adolescent development, how are parents involved in their adolescent's health? What roles and responsibilities do they have?

Parents clearly play a critical role in promoting and safeguarding their children's health, and psychological and social well-being. These tasks and responsibilities are numerous and include at a minimum: teaching basic health and safety and good nutrition practices; teaching values and setting clear behavioral rules and expectations; responding promptly to evidence of illness and getting appropriate treatment; complying with prescribed regimens, etc.

It is not often acknowledged that these tasks continue throughout adolescence but take on a different tone and color over time as parent and teen renegotiate their basic relationship so that the teen gradually assumes more responsibility for his or her health care and decisionmaking. Parents' roles shift as they become more of an advisor, counselor, monitor, and supporter. Nevertheless, they usually remain the best source of information about the teen's medical and family medical history. Parents continue to facilitate and mediate many of their teens' contacts with institutions and offices, helping the teen learn to negotiate through the maze of health care providers, especially when any illness occurs or the teen has a chronic disability or condition.

Parents also have very important roles in helping to prevent or modify health damaging behaviors such as drinking and driving, unprotected sex, drugs, etc. through providing information and education, clarifying values and expectations, setting an example, and sometimes intervening strongly when the teen stumbles. And of course one of the parental tasks is to develop increasing respect for their teen's privacy especially in areas of sexual behavior.

More studies needed about parents' role. As the OTA report points out, we need much more research to document in detail the positive contributions parents can make to adolescent health and well-being, and how these can vary for families of different socioeconomic, racial, and cultural backgrounds. We also need studies of interventions that aim to encourage and strengthen parents' role. Such studies would have important implications for health care professionals in designing both prevention and early intervention programs.

One example of the kind of research that needs to be done is a longitudinal study conducted in 1984-87 to investigate and compare parent and peer effects on a wide range of adolescent health behaviors. (Questionnaires were administered to 908 teens in five New Jersey communities at three time periods over three years, and phone interviews were conducted with 600 of the parents.) This study found that the key determinants of positive teen health practices were high levels of engagement in parent-oriented activities such as eating dinner together and attending church. But high levels of social activities with peers were associated with negative health behaviors over time (Hansell and Mechanic, forthcoming).

One of the strongest findings in this study was the association of teenagers **perception** of parental interest with positive health behaviors. Interestingly, teens and parents responses about their relationship only showed modest correlation suggesting, the authors conclude, that many well-intentioned parents may lack the communication skills necessary to convey their interest and concern to the teen.

Another series of studies which focus on the characteristics of competent parents have implications for parents' promotion of teen health. Baumrind's research, conducted on samples of white

middle class teens, has shown that adolescents whose parents use one of two parenting styles, dubbed as "authoritative" and "democratic" are better socially adjusted, are in better mental health, and more cognitively competent than their peers from either "authoritarian" or "permissive" homes (Baumrind, 1987). However, it is interesting to note that adolescents who experience "democratic" styles of parenting were found to smoke marijuana more.

Others have mentioned the preeminent importance of communication between parents and teenagers. Whatever disputes occur between them parents need to keep open the lines of communication and be willing to talk and listen to their adolescents. And most importantly, parents need to make sure the teen knows that whatever trouble he/she is in, the parent is still interested and still cares. The presence of a supportive, caring parent or other adult has been cited as the key factor in the lives of resilient children from otherwise disadvantaged backgrounds.

Finally, a number of studies emphasize that in addition to these personal characteristics, in order to be able to be effective parents during adolescence parents need marital support (or support from some other adult), informal support from their peers, and support from formal support systems such as their workplace and social agencies (Small, 1990). The experience of parent support groups sponsored by schools and parent health related organizations in the disability, mental health and substance abuse area are testimony to the importance of these kinds of support (see Ooms and Owen, 1990).

In summary, research to date provides a strong rationale to encourage health care providers to find appropriate ways of involving parents and other family members in their services to adolescents and suggests that if they do so the services will be more effective. Some of the ways to do this are discussed below.

CURRENT SYSTEM'S RESPONSE TO ADOLESCENTS' HEALTH NEEDS

(Sources: Dryfoos, 1991 b; Gans, McManus, and Newachek, 1991; National Commission, 1991; U.S. Congress/OTA, 1991)

The three major recent reports on adolescent health concur that large numbers of adolescents are not being adequately served by the present health care system, as indicated by low utilization rates and by the number of those who have no or inadequate insurance coverage. They conclude that the basic design and organization of the health care system is out of sync with adolescents' needs and requires major change. This conclusion holds true for teens across income levels but especially for teens from low-income families.

Low utilization and lack of care. On national surveys, adolescents exhibit low utilization of the services of primary care physicians and other health care providers. For example, adolescents constitute 17% of the U.S. population but only make 11% of the visits to primary care physicians. Yet they experience a greater incidence of acute conditions than adults. Few teenagers receive regular preventive care including dental care. Often the services they receive do not address many of their health care problems, which apparently often remain untreated. Fewer than one-third of youth estimated to need some type of mental health service received any kind of mental health treatment. And only 10% of adolescents who drank alcohol excessively were in alcohol treatment in 1987.

Insufficient financial access. The reports devote much useful discussion to the problems of teenagers' financial access to health care. Fifteen percent of teenagers are not covered by either public or private health insurance and about one in three of poor or near poor teens have no

coverage in spite of Medicaid and SSI. They also point out that while 85% of teens do have some kind of health insurance, the services many teens need typically are not covered---such as outpatient, mental health services, preventive care, and long-term, community-based care for chronically ill and disabled youth. However, as several of the reports point out, for Medicaid eligible teens, the Early and Periodic Screening, Diagnosis and Treatment Program offers a greatly underutilized vehicle for both diagnosis and a broad range of treatment.

Lack of insurance is a problem that affects all age groups in the population. (In fact, the group least likely to be insured is young adults age 19-26.) Yet, even if all adolescents had insurance coverage the present system is neither financed, organized, nor delivered in a way that meets adolescents' needs. Why do teens present a unique challenge to the health care system? The reports highlight several reasons why there is such a mismatch between teens' needs and services that are available.

Access problems due to unique transitional status of adolescents

A major reason for low utilization is the fact that teenagers are in transition between childhood and adulthood, yet health care services are designed to be accessed by autonomous adults. Teenagers are still dependent on their parents financially, physically, and legally, and yet in many aspects of their lives they are assuming greater autonomy and control and insisting on privacy. This means that if a teenager became physically ill or has an accident the traditional system-----if working as intended---generally serves them adequately. The parent or other adult helps them get to, and pay for, the service they need whether from the private physician's office, in a public health center or clinic, or hospital emergency room.

If, on the other hand a teenager is experiencing any of the problems that are most prevalent and worrisome at this age (although not unique to it) such as acne, venereal disease, substance abuse, pregnancy, depression, and relationship problems the question of access becomes much more complicated. On these issues teens are often reluctant to tell their parent or another adult, or if they do are less likely to accept their advice. The balance shifts: Parents are no longer in the driver's seat, they are no longer the primary mediator of their adolescent's health care. The teenager him/herself becomes the first gatekeeper to accessing the health care system. Many teens experience a range of significant hurdles they have to cross before they get the care they need.

Typically teens may deny the seriousness or significance of the health problem, may not know that there is help available to treat it, are scared to admit the problem, ambivalent and fearful about what getting help entails, and embarrassed to seek help for any of these problems. On some of these issues they are very fearful of telling their parents or even their friends. They are often not experienced enough to know where to go, what information to share to the health care provider, or what questions to ask. They may not know much about their own medical history or their family history. They may not have money to pay for the service, or if the family is on Medicaid, may not want to share the number for fear the parent will find out. They may not understand the need for, or have sufficient motivation to seek out, preventive services.

A final set of barriers has to do with adolescents difficulty in finding the type of care they need in order for them to use it appropriately. For if and when they do contact a health care provider adolescents need to develop trust and have sufficient time with that person to be able to share their worries and concerns, since typically the presenting symptom masks a host of other problems. As we shall see below, this type of care is frequently not available.

Ideal characteristics of a system designed for teens and their families

There is a growing consensus among health care providers specializing in adolescence on the characteristics of a system that would meet their needs. There is a beginning understanding of some of the characteristics of programs that meet the needs of their family, as well. These characteristics are outlined below.

Easy access and convenient. In order to overcome many of these psychosocial barriers services need to be organized so that they are easy for teens to get to, offered at times that are convenient, and, if of a sensitive or confidential nature, must be offered free or at very low cost and in a non-stigmatizing manner.

Trained, caring providers. Equally critical factors in effective health care are the characteristics of the primary health care provider who needs to:

---Understand teenagers' special developmental and health needs and disorders;
---Recognize that many teens' problems and concerns are interlinked and know how to screen for related problems beyond the presenting symptom;
---Know what services are available, and how to successfully refer to them and coordinate them;
---Be skilled at motivating the teen to get help;
---Spend enough time to get to know the teen and explore his or her situation thoroughly;
---Know when and how to involve the parents or other family members.

Coordinated, continuum of services. Teenagers should be able to count on a range of services to meet multiple needs and that these services are sufficiently coordinated that they reinforce each other and the teen can move easily from one to another.

Provision for individual counseling. Health care providers who work with teens report a growing demand for one-on-one individual counseling. Although patients may initially present themselves for screening or emergency care, what they really want is someone to talk to.

Patient confidentiality. This issue is often publicly presented in stark terms, namely that either parents have to be informed in order to provide consent or they do not. Little distinction is made between notification and consent. Health care providers trained to work with adolescents and family professionals recognize that they have to walk a delicate tightrope with respect to patient/client confidentiality. The issue usually only arises with respect to sexuality related care and parental physical abuse, but may also be a concern for teens abusing drugs or having emotional problems. While in general, health care providers respect the confidentiality of any patient or client, adolescent health care providers realize that in many situations they must tell the teenager that his or her parents eventually must be contacted and involved in treatment. Such as when:

---The problem poses such a hazard/danger to the teen or others that parents should be told since they have ultimate legal and moral responsibility for the child's well-being---e.g. suicidal threats or tendencies, serious drug taking, etc;

---And/or that the provider cannot really understand or advise about the problem without obtaining from the parents information about the teen's health history, social circumstances, or about the parents' own behavior, which may contribute to the teen's problem.

---The parent's involvement is necessary to reinforce and support effective treatment---as is generally the case with problems of mental health, substance abuse, and with many types of physical illness.

Service providers, thus, must strike a balance between respecting teen patient confidentiality and being "family-friendly." They also generally need to make the distinction between the need to notify parents and get their input while taking care to protect the adolescent's right to consent to his or her own medical care.

Family-friendly services. All three major reports---especially the Code Blue report---mention the need for family-centered services but do not spell out in detail what this means in terms of professional/clinic practice. Many family professionals, drawing on their knowledge of the role of parents in adolescent development and well-being, consider "family-friendly" services to mean that the service provider or health care program should:

---In general, encourage parents to share information and concerns about their teen's current condition or health history that will be useful to the provider. Assure them that the parent can expect to be informed about the results of diagnostic tests, prescribed treatment, etc., with the exception of certain very sensitive issues generally considered confidential.

---Explain to both teens and parents, in writing and verbally, the confidentiality policy and clarify the circumstances in which the professional believes it is imperative to share information with the parent or other health care providers, always informing the teen that they are doing so.

---Encourage the teen to include the parent in collaborative consultations and/or treatment whenever this will be of direct benefit to the teen. Be willing and able to mediate issues of conflict or misunderstanding between parent and teen or refer them to people who have these skills.

---Encourage parents to share information with the health care provider about any personal or family issues of relevance to the teen's health and well-being. Be available to help refer parents to sources of help for these personal or family problems.

---Most importantly, encourage and help parents find ways to provide appropriate caring and support for the teenager even when their behavior is so difficult to accept.

---Provide or steer the parent(s) to other sources of information about adolescence, and resources, services, and sources of peer support---such as parent support groups---that will help them provide a more supportive environment for their teen. Information about adolescence needs to be available to parents before their children enter their teenage years as a preventive measure.

---Involve parents on various advisory/governing bodies along with teenagers themselves.

In summary, being "family-friendly" implies communicating directly with the parent---which may not always be easy to do--- and providing them with some level of services. Increasingly, some adolescent health care programs are moving in this direction, especially those based in school settings.

Shortcomings of the present system

These broad, critical components of appropriate and quality health care for adolescents are now widely accepted. Using these yardsticks the OTA, AMA, and NASBE/AMA reports found the organization and delivery of the present service system had the following major shortcomings.

Problems of physical access. Most traditional health care services are difficult to get to, especially for low-income and rural teens. Most private physician offices and public health clinics are not open on evenings or weekends and may be located some distance from home or school.

Not enough trained health care providers. Many physicians and allied health care professionals are not competent to meet adolescents' special needs. For example, one survey reported that nearly 40% of physicians and nurses believe they are unprepared to treat adolescents who have alcohol or drug abuse problems, are depressed, or at risk for suicide. Many report their inability to diagnose and treat teens' emotional problems.

It is not clear who should be providing adolescents with care---pediatricians, family physicians or internists, or nurse practitioners. At least a third of pediatricians do not accept adolescents over age 15 as new patients, and other primary care physicians express little interest in serving adolescents. There is a serious shortage of any of these providers who have specialized training in adolescents. Health care providers are even less likely to be trained to provide culturally sensitive care to minority adolescents.

Adolescent medicine has only recently become a recognized specialty and there are very few training programs. There is approximately only one adolescent medicine specialist for every 20,500 adolescents. In 1981, the federal government reduced their level of support for interdisciplinary training programs in adolescent health from nine to six. Many believe the critical need is for more nurse practitioners since most adolescent health problems do not require a physician. Increasingly, the primary health care providers in school-based clinics are nurse practitioners and social workers.

Barriers in office practice. Half of all teens' visits to physicians in private practice take less than ten minutes and only a few seconds are spent on health education related to the new morbidities. Those teens who seek care in public health clinics or emergency rooms are no more likely to receive more attention, although studies suggest that teens served in school-based clinics do spend more time with the providers.

Fragmentation of services. Beyond the primary care sector most health care treatment services, both in the private and public sector, are organized around a single diagnosed behavior or illness, for example, pregnancy, substance abuse, eating disorder, etc. This is even more true of preventive health care, a field in which there is a plethora of separate programs. As noted above, many teens experience several, interrelated health problems. The fragmentation is a major barrier to their receipt of the coordinated and holistic care they need.

Legal barriers. All these reports cite as a substantial barrier to treatment the ambiguity and state by state variations in the law with respect to teen confidentiality and parent notification and consent. Consequently, many health care providers are reluctant to provide confidential care even when it is legal to do so in a particular state. As a result many teens are concerned that their confidentiality will not be protected. However, the studies that have found some evidence of this barrier effect are restricted to family planning and abortion services. Whether confidentiality poses a serious barrier to other kinds of health care services has not been investigated (see especially OTA report, Vol III. chapter 17).

Barriers to family involvement. These recent assessments of adolescent health care have not examined the extent to which the current health care system is "family-friendly," nor has this been the subject of research. Being family-friendly implies communicating directly with the parents and providing them with some level of service. While many health care professionals do reach out to parents, the literature describing many of the comprehensive health programs for teens suggests that many programs for teens have little or no contact with their parents. Increasingly, it seems that the innovative programs are becoming more family-focused as they understand the extent to which teens destructive behaviors are often rooted in family problems and circumstance and that teens' parents can usually be a powerful source of leverage in helping teens modify their behavior.

SCHOOL-LINKED, MULTI-SERVICE CENTERS FOR YOUTH

(Sources: Dryfoos, 1991 a and b; Hyche-Williams and Waszak, 1990; Lear, *et al.*, 1991; Millstein, 1988; National Commission, 1991; U.S. Congress/OTA, 1991, Vol. III, Ch. 15)

Many of these barriers can be overcome if services are provided in a school-based or school-linked center which provides comprehensive and coordinated, health and social services designed specifically to serve teenagers. All three reports laud this emerging new model as having great promise. The school-based, school-linked model is attracting a great deal of public and media attention. Several hundred demonstration programs are in operation in communities across the country and at least ten states are investing, or planning to invest, considerable state resources in supporting sites across their state (see page 23).

What is the history and background of these school-based clinics (SBCs)? What services do they offer and how are they organized, financed, and administered? And what are the critical issues that both advocates and sceptics need to address in the future?

Background and History of School-based Clinics

School-based, or school-linked, multi-service centers are attracting a great deal of positive interest among professionals and policymakers. They offer a radically new way of assuring that adolescents get the health care they need. School-linked, multi-service centers are designed to overcome the major barriers to access and quality of care that are embedded in the present system. All three major reports have cited the comprehensive services model as a highly promising vehicle to deliver health care to teens.

In her review of 100 successful programs designed to combat adolescent pregnancy, substance abuse, school failure, and delinquency, Dryfoos points out why most of the successful programs were school-based. She believes this is in part because it makes them more accessible to more youth, because the school setting offers a safe, stable environment, and because so many kids with health problems also have problems in the classroom and it is easier for the health and education staff to communicate with each other. Schools welcome these programs offered by community agencies to help them cope with the problems engendered by the "new morbidities."

On the other hand there are some advantages to locating programs away from the school. Adolescents themselves may have some concerns about having health care centers situated in the schools. It may be easier to offer controversial services such as contraceptives, and youth who have dropped out of school may be more likely to be served. The AMA report believes it is somewhat premature to recommend the school as the preferred setting for such a model and that

hospitals or other community-based settings might be equally good or even in some situations preferable.

Common components. There is wide variation among settings, services offered, staffing, and administration among school-linked service centers but they share a common core of components. They all provide a wide range of medical, counseling, and social services for no fee in a single location that is highly accessible to teens---on or very near the school premises. The majority are situated in high school settings, but increasing numbers are being opened in middle and junior high schools. The centers are staffed by several different types of health and social services specialists, all of whom are experienced in working with teenagers. All are open during school hours, some are open after school and on weekends, and a few remain open during the summer vacation.

The sites serve predominantly low-income populations in urban areas with high proportions of minorities, populations deemed to be seriously "at risk" of engaging in multiple destructive behaviors. However, all the centers and clinics are open to the entire school population, 30% of the clinics responding reported that they served school-dropouts. Most SBCs require that a parent consent form be filed before the student can enroll in the clinic/center and receive services.

Initial controversy. School-based clinics initially ran into a great deal of controversy in some communities due to the publicity given to their sexuality-related services. More recently this controversy seems to have abated somewhat as their purposes and services have broadened and the programs have sought firmer bases of public support. Their growing acclaim, however, should not obscure the fact that many questions remain to be answered about the quality of care provided in these centers, the impact of these centers on health outcomes, and most importantly how they can be assured financial stability. And although many of the programs themselves are findings ways to work with and meet the needs of teenagers' parents, the issue of how these programs can be designed to be family-sensitive, within the constraints of respecting teen confidentiality, has received little official discussion, study, or debate.

History. The dramatic growth in the number of school-based clinics occurred in the past decade. In the early eighties there were perhaps about a dozen independently operated clinics, by 1988 there were at least 125, and estimates are that this number has more than doubled in the last three years. Among these are included a number of centers which are located adjacent to or nearby the school, or have established other strong linkages with schools and hence the wider umbrella term came into use, "school-linked." Yet in spite of this growth the numbers of such centers remain small when compared with the total adolescent population: most adolescents do not have access to such centers.

The roots of the school-based/school-linked model go back to the sixties when a handful of community-based, comprehensive health centers for adolescents were set up. These centers were designed to meet the needs of the growing numbers of alienated or street youth by offering a variety of health and related services at a single site, at no cost, and often on a drop-in basis. Among them, perhaps the prototype is The Door in Manhattan, New York City, which has received a great deal of attention and acclaim and still flourishes today. Others include the Haight-Ashbury Free Clinic in San Francisco and the Free Medical Clinic of Greater Cleveland, founded in the sixties, which in 1989 opened an adolescent clinic adjacent to its runaway youth shelter. These clinics were largely funded by private foundations and received very little money from public programs.

Much less publicity has been given to an unknown number of adolescent health care programs which began to be set up in hospitals and other health care settings, often initiated by the graduates of the newly established adolescent medicine training programs. These centers were operated by a

team of health care professionals specializing in adolescence. The primary aim was to provide a coordinated array of health services. While the primary focus was on physical health, screening for mental health, substance abuse, and other problems was usually routine and referrals were made to these services.

Many of these centers received financial support from the Robert Wood Johnson Foundation which in 1982 awarded twenty, four-year grants to teaching hospitals to work with 54 community-based agencies as part of its program to Consolidate Health Services for High-Risk Young People. The clinics, however, also received some amounts of money from public funds such as Medicaid. An evaluation of the Robert Wood Johnson funded programs reported quite disappointing results in terms of health outcomes. It is believed that one reasons may be that such medically oriented clinics may not have the leverage or resources to help teens modify their behavioral, environmental, and lifestyle problems that are so central to their health status.

The first well known school-based clinic to offer health-related services which also included a strong emphasis on reproductive services was established in a senior high school in **St. Paul, Minnesota** in the mid-1970s. This clinic's clear, primary aim was both to reduce the incidence of teen pregnancy and to assure healthy maternal and child outcomes for teenagers who gave birth. Since the program's evaluation reported a significant decline in teen birth rates, the program achieved much national attention. (Note: it was never clear how much of this reduction was due to a concomitant rise in abortion rates or other mediating factors since abortion data were not available and there was no comparison or control group.) Early in its development the St. Paul clinic changed from its initial family planning orientation to providing more comprehensive services in order to attract more students.

The school-based movement then began to take off and many other communities started clinics resembling the original St. Paul's model. While all these clinics provided a range of health services, the rubric under which they tended to be promoted, and by which their success was assessed, was their role in teen pregnancy prevention. Controversy swirled around whether schools should be in the business of providing advice about, access to, or even directly prescribing contraceptives. Opponents asserted that this would provide official sanction for undesirable (immoral) sexual activity and would directly encourage such activity. Clinics placed a great deal of emphasis in the planning stages in getting widespread input, advice, and support from community leaders and parents, in part, to assure that whatever controversial services were provided had broad community support. While nearly all provide counseling on birth control methods, pregnancy, and other aspects of sexuality, in a 1990 survey of SBCs only 54% of respondents said they wrote prescriptions for contraceptives and only 21% said they dispensed contraceptives.

Among the medical services most usually offered in SBCs were general and sports physicals, diagnosis and treatment of minor injuries and STDs, pregnancy tests, immunizations, lab tests, and chronic illness management. Over 90% prescribed medications. The primary counseling services included mental health, family, alcohol, and other drug abuse, nutrition, and weight reduction (Hyche-Williams and Waszak,1990).

Robert Wood Johnson School-Based Clinics. Clearly impressed with the evolving model of SBCs, in 1987 the Robert Wood Johnson Foundation launched a six-year, 23 site, $14.5 million **School-based Adolescent Health Care Program.** This program was designed to test on a large scale the ability of school-based health centers to increase access to health care for low-income youth. This program provided start up money to communities and required a collaborative effort involving schools, health care providers, and community advisory committees to establish a comprehensive range of services in public secondary schools. The grantees are located in 11 states and 14 cities and sponsors include academic health centers, county health

departments, school systems, teaching and community hospitals, and not-for-profit agencies (Lear, *et al.*, 1991).

The center staff generally include a full-time medical assistant/receptionist and nurse practitioner or physician assistant. Some social workers were full time, others part time. Additional specialty personnel on a part-time basis included physicians and additional mental health personnel. The most predominant type of care provided was for treatment of acute illness and injury, followed by mental health-related services, physical examinations, immunizations, etc. Very few services related to substance abuse are provided by these clinics. In their first three years of operation the centers saw a steady increase in the numbers of students who had parental permission to obtain services from the centers.

Mathtech, Inc., in collaboration with Mathematica Policy Research, Inc., is conducting a process analysis and an outcome study of the Robert Wood Johnson clinic services. Two baseline reports on all the students in an entering class in the site schools have been completed. There will be follow up interviews at two additional points in time with the same students. A survey has been completed of a nationally representative reference sample of students from cities of over 100,000 which will be used as a comparison group. A final report will be available in early 1993.

Building on the experience of these and other programs, the most recent wave of school-based programs, many funded directly by state government, appear to be offering a wider range of services. These services include a stronger emphasis on mental health and substance abuse counseling, sometimes include employment and vocational services, and some kinds of recreation activities and, hence, are now more often named centers than clinics. State grants are provided to schools and community agencies to put together the packages of services most needed.

School health services. As Millstein pointed out (1988), another root of the school-based health services movement lies in the direct health services provided since the end of the nineteenth century by schools themselves. Originally concerned with the spread of infectious diseases, nowadays, in nearly all communities, schools fund a number of narrowly targeted school health services which expand or contract in scope depending on the communities' interests and willingness to fund. (For example, some schools provide routine vision, hearing, and dental exams.) Most school districts now fund school nurses to provide on-site "band-aid" type of emergency care when children become ill or suffer an injury while attending school. (They are seldom full time in any one school however.) Nurses will occasionally do routine physicals and they review immunization records. More recently, nurses at high school level have been used by students to seek advice about suspected pregnancy or other health concerns and serve as a source of referral. Nurses may also play a critical role in facilitating reports of suspected child abuse (initiated by the classroom observations of teachers). Increasingly, schools are offering student assistance programs, modeled on workplace employee assistance programs, that provide initial diagnostic and referral services related to alcohol and other drug use.

In the past decade schools have assumed a much greater role in promoting prevention, health education, and early intervention programs, especially in the areas of substance abuse, pregnancy, AIDS, and suicide. Usually each of these efforts are separate and receive separate funding. They involve educators, school health personnel, and outside experts. A few schools are providing comprehensive school health education programs with fuderal funding from the Office of Education Research and Improvement, Department of Education.

School-Based Clinics: The new collaboration

The school-linked, multi-service center program model represents a new and unique collaboration between education, health, and social service sectors. Educators clearly realized that they had neither the expertise, time, nor mandate to meet the burgeoning health and social service needs of today's teens. Most of all, they lacked the funds to do so.

School nurses, guidance counselors, and school social workers, with caseloads of hundreds or thousands of students, found they could not begin to address their students problems adequately. While this has been well known for many years, what is new is that the education community began to publicly admit that teens' health related problems---especially the new morbidities---had a clear, negative effect on students' learning. Educators at school, county, state, and increasingly national levels began to view the school-based clinic/center as a service that the education community had a direct investment in facilitating and supporting. At the same time, health and social service personnel based in the community were frustrated by their inability to reach and properly serve teens. Thus, the fundamental assumption underlying these centers was the need for a collaboration of specialized services between existing sectors.

Most SBCs are actually administered by a non-education agency or organization which assumes fiscal and administrative responsibility for the program--most of them health -related organizations. Only 7% of the school based and school-linked clinics surveyed by The Center for Population Options (CPO) in 1990-91 were run by school districts themselves. (This proportion will change however with the new California legislation which will fund a hundred new programs to be administered by local education agencies in collaboration with other organizations.) The others were run by public health departments, hospitals and community clinics, and other organizations. However, in all cases the school system provides substantial in-kind resources, such as the facility, maintenance, security, and, access to students. In perhaps half the centers the school nurses are integrated into the staff of the center.

Sharon Lovick, former director of the CPO Support Center, believes that there are several advantages of the school system being an active collaborator but yet not in control of the program. A program run by a non-education agency or non-profit organization gets bogged down in educational bureaucracy less often and is somewhat less vulnerable to community criticism. Moreover, if the center staff are separate from the school, the confidentiality of center records are easier to protect from school personnel (personal communication).

Another key feature of the school-based clinic movement is the involvement of some kind of broad based community advisory board or committee in the original planning and ongoing operations of the center. Members of this group would normally include parent and teen representatives from the community, representatives of the health care professions, youth serving agencies, religious and business leaders, and others.

Staffing of the centers also varies a good deal but always involves a number of different specialists, many serving on a part-time basis. The team approach is central, often backed up by a central counselor, who may be full time, who serves as coordinator or "case manager" for the teens using more than one discrete service. Typically most staff would have a primary interest in, and experience with, adolescents and some have special training.

ISSUES AND QUESTIONS

(Sources: Hyche-Williams and Waszak, 1990; Kirby, Waszak, and Ziegler, 1989; Newacheck, McManus, and Fox, 1991; Millstein, 1988; OTA, 1991, Vol I and III, Ch. 15.; Waszak and Neidell, 1992)

Financing: What is the federal role?

Although there is a growing constituency enthusiastic about the school-based, multi-services model, their lack of stable funding is a grave concern. (The average SBC cost is about $100,000 per year, although there is a wide range.) As the SBC movement moves beyond the demonstration phase to widespread replication, the issue of finding new and stable sources of funding becomes critical. Currently, most SBCs are supported by a complex patchwork of funding streams absorbing a great deal of administrator's time to create and administer.

The financing of SBCs varies from center to center but usually includes a mixture of private and public funds. Their major sources of funding are private foundation grants and county, state, and federal monies. The major federal health programs being tapped are Title V, Maternal and Child Care Block Grants, EPSDT, Medicaid, and to a lesser extent Title X and Title XX (family planning), but in 1989-90 only 2% of funding for SBCs and 4% for SLCs were provided through Medicaid reimbursement. Over the years the share of funding from the public sector has increased from 64% to 70%. And within the public sector the share of federal support has declined. The states and counties are now giving much greater levels of support, rising from 16% in 1985-85 to 47% in 1988-89, and the federal share declined from 27% to 11% over the same period. (These trends are illustrated on Table I, page 37, providing data from the Center for Population Options annual surveys.) The next CPO annual report to be published in 1992 will probably show an even greater increase in the share of state funds due to several new state initiatives. Third party reimbursement from private health insurance has been a negligible source of funding.

Support from private foundations is likely to diminish since they view their role as initiating innovative demonstrations not providing permanent funding for services. For example, the R.W. Johnson six-year grants to 23 sites will end in 1993. If states' investment in SBCs becomes more widespread and they begin to be viewed as a permanent part of the health care system, the momentum will undoubtedly build to seek increased federal support.

Some believe that both the Title V programs and Medicaid program could be tapped for support to a much greater degree than they are at present. One recent report suggests that both Medicaid administrative funds and the Early Periodic Screening, Diagnosis and Treatment Program could support SBCs (Newacheck, McManus, and Fox, 1991). Among the barriers to doing so are federal and state regulations, or interpretations of regulations, that do not permit funding medical services to be delivered in non-medical (school) settings or that require direct physician supervision. Plans are underway in California to make it considerably easier for school-based programs to access MediCal/EPSDT funds (see p. 24). Even if existing funding streams could be better used, many of the services provided by these teen centers, by their nature, are not reimbursable (either because they are not tied to medical diagnoses or are not considered covered services). Hence, some kinds of general grant support, whether from private or public sources seem inevitable.

The OTA report recommends three financing strategies related to federal funding of SBCs under the report's **Major Option 1: Congress Could Take Steps to Improve Adolescents' Access to Appropriate Health and Related Services** (OTA, 1991, Vol I, p. 46-54).

(i) **Strategy 1-1a:** Provide federal **seed money** for the development of school-linked and other community-based centers that provide comprehensive health and related services to adolescents.

(ii) **Strategy 1-1b:** Provide federal **continuation funding** specifically for already established SBCs.

(iii) **Strategy 1-1c**: **Reduce**, through legislation or regulation, **existing barriers** to the delivery of comprehensive services in adolescent-specific centers.

Pending federal legislation

In the U.S. Congress, two Senate bills were introduced in 1991 related to providing new direct funding for school-linked collaborative services for teens. The Link-Up for Learning Demonstration Grant Act, S. 619 is co-sponsored by Senators Bradley and Kennedy. The bill authorizes $50 million for three-year grants to local school districts who must collaborate with other public or private agencies to coordinate and improve access to school-based or community-based health and support services. Services must be targeted to local school districts eligible to receive Chapter I funds. Not more than 50% of the grants may be used for direct services. The other 50% can be spent on coordination, administration, planning, training, etc. These funds must be matched 1:1 by other sources of funding. The program would be administered by the federal Department of Education. The bill also establishes a Federal Interagency Task Force to facilitate interagency collaboration at the federal, state, and local levels.

The Comprehensive Services for Children and Youth Act of 1991, S. 1133, is sponsored by Senator Kennedy and is very similar to S. 619 with the major difference being that the federal share of the projects is 80%, and the grants may be five years in length. S. 1133 also introduces the concept of bonus awards to projects that achieve successful outcomes.

Evaluation

Note: The Center for Population Options (CPO) in Washington, D.C. has been funded since 1985 to run the Support Center for School-Based Clinics which serves as an information and technical assistance clearinghouse for school-based and school-linked centers. It also serves as the best current source of utilization data about these programs in that it conducts an annual survey of existing SBCs, but outcome data is not available in this survey. The most recent 1990-1991 annual survey sent questionnaires to 328 clinics of which 298 were school based and 30 were school linked. 73% of the clinics responded, the highest response rate to date. The R.W. Johnson Foundation's evaluation of their school-based programs, conducted by Mathematica Policy Research Inc. and Mathtech, Inc. will have a report in 1993. And there should be a considerable amount of information made available from the evaluations of the recent statewide school-based initiatives (described on page 23).

The field is so new, the goals so numerous and the programs so complex, that few attempts have yet been made to conduct any comprehensive evaluation of SBCs, especially any that attempt to assess health outcomes, although several are being planned. Some evaluation data have been reported but they usually relate to utilization patterns and the types of services provided.

There has been one multi-site evaluation of six school based clinics conducted by the Center for Population Options which OTA considered to be "fairly rigorous" in its methodology. Although the evaluators found that large numbers of the students used the centers (between 40-70%),

findings with regard to health outcomes, and any changes in risk-taking behavior varied so much by school that no conclusions could be drawn about effectiveness. The study did find, however, that the clinics did **not** increase the levels of sexual activity, one of the major predictions of opponents of the centers (Kirby, Waszak, and Ziegler, 1989).

The focus and design of any comprehensive evaluation of the SBCs poses many methodological challenges. As one evaluation team has commented "the school-linked services projects in development (in California) are multi-dimensional, aimed at changing child clients, their families, their neighborhoods, and supporting institutions. An evaluation strategy must therefore allow for focus on all four levels (or any combination thereof) simultaneously" (McCroskey, Kirst, and Brindis, 1991). In their initial stages, formative or process evaluations will be key in learning how to best get these projects off the ground. Once some level of stability is achieved, plans for documenting outcomes can be introduced. However, it may be extremely difficult to get agreement on what outcomes are both important and can be easily measured. Comparisons between sites will be extremely difficult given the variation in design, setting, and components between them. Experimental, randomized designs are highly unlikely.

Another issue that evaluations will be pressed to study is the question of costs, and cost effectiveness which again confront many methodological problems. Whereas short-term savings may be difficult to demonstrate, the long-run savings in health care costs, for example simply reducing adolescent smoking, could be considerable. And a final issue is whether these clinics are reaching those teenagers who are the most in need (many of whom have dropped out of school).

Quality and Staff Training

Another issue is that of quality of the services provided in these centers. While there is no doubt that many teens are getting more health care and a wider spectrum of health care related services than they would have if the centers did not exist, there has been little study and discussion about the quality of the services provided. Are students' health problems being accurately detected and treated? Are appropriate referrals being successfully made? How are the programs linking with the private physicians in the community? To what extent do professionals providing different services to a teenager really coordinate their approach with each other? How do the centers handle inter-staff confidentiality and confidentiality between center staff and the school personnel?

The CPO evaluation and other studies have raised a number of other issues and made many suggestion for improvement, some of which have been incorporated in the newest centers. These include how to help the school-based centers reach out and serve students who have dropped out of school---an important, needy, and underserved population especially in the low-income areas. And how to reach a larger percentage of the school population, for example, by requiring routine exams for all students, providing attractive, recreation-oriented programs, etc.

These questions relate to both the qualifications and training of staff and issues about the effectiveness of referral and follow up, neither of which have been studied to date. There is also concern that the shortage of specially trained professionals will hinder the setting up of new centers. Moreover, it is especially difficult to recruit black and Hispanic nurse practitioners and social workers.

Family-friendly practices

Finally, there is the concern that the SBCs potential for strengthening and improving parent-teen relations and enhancing parents' role in promoting their teen's health has not been given sufficient attention. They believe this is an issue not simply related to gaining parent and community support but is at the core of delivering effective services. The new California legislation, SB 620, clearly specifies that the funds may be used to provide services to the family (see p. 24).

States or individual centers that aimed to make their services more "family-friendly" can find some good examples of practices and policies to emulate, although they are not well known. Implementation of family-friendly policies and practices should include:

---Asking parents on the advisory board, in the community through focus groups, or through a survey of parents of students who use the services their assessment of the services provided; whether and how they would like to be more involved; and what specific information or services they need to help them help their teenagers.

---Schools could require that the family and teen together fill out a basic medical history form which could be on file along with the parent consent form and parents should be encouraged to contact the center personnel with their concerns about their teenagers' health status or health-related behavior.

---Parent consent forms could be rewritten to be more family-friendly and include information about what feedback they will be given, explain the confidentiality policy, etc.

---Center staff should be given training in how to communicate with parents, enhance parent-teen communication, and know how to assess when and how a family needs referral for other, specialized services. Center staff should also be trained on when and how to conduct home visits to those parents who are, for a variety of reasons, hard to reach. Counselling/mental health staff can be given specific training in short-term family therapy.

---Holding frequent "open houses," inviting parents to health fairs and providing a parent/ teen newsletter on health education issues.

---Finally SBCs could help parents access services that they and other members of the family need through information and referral. SBCs may even choose to provide some services directly to family members themselves.

STATE SCHOOL-LINKED YOUTH SERVICES INITIATIVES

Legislation has been introduced in many states over the past decade to support school-based and school-linked centers, though it has often not been enacted. However, described briefly here are seven states that are already funding, or are about to start funding, ambitious school-based, multi-service initiatives in several sites. In some these are statewide initiatives, and in others the initiative is targeted on only one or two counties. In several states the initiative is targeted solely on the senior high school level. In others, such as California, New York and Kentucky, the centers are located in elementary, middle and senior high schools. (School-based service initiatives are also underway in Illinois, Connecticut and Iowa and perhaps other states.)

California

Currently there are 20 school-based health clinics in California which are funded from multiple public and private sources including MediCal and the Tobacco Surtax Fund monies channeled through the counties. Five are funded by the Robert Wood Johnson Foundation as part of its School-based Adolescent Health Care Program. Several of these clinics do provide mental health services, but otherwise they provide a somewhat traditional set of health-oriented services. The Center for Reproductive Health Policy Research, at the University of California, San Francisco is conducting ongoing evaluations of eight of these centers.

New program: Healthy Start Support Services. In 1991 new legislation was enacted that will provide funding for school-linked centers which will potentially provide a much broader range of services to students and their families at all age levels. The Healthy Start Support Services for Children Act (SB 620) will provide both planning and operational grants to local education agencies (LEAs) or consortia of LEAs for programs to provide support services to eligible pupils. The LEAs will serve as fiscal agents with the local collaborative partnerships having the administrative and operational authority. (Eligible pupils are defined as children who attend a school in which 50% of students are eligible to receive free or reduced price meals, are from AFDC families and/or are limited English proficient.) Appropriations for this bill come from the State General Fund.

Support services to be provided through these grants include: primary health care, mental health services, substance abuse prevention and treatment, family support and parenting education, child care and early childhood development programs, family and suicide prevention counseling, and nutrition services. A case management system is a required component and must include plans to establish an individualized, computerized client tracking system.

Family involvement. The emphasis on services to families is expected to be especially strong in the centers linked with elementary schools. The RFP issued in February 1992 from the State Superintendent Bill Honig emphasized that "There are no restrictions on the extent to which services may be provided to family members. The goal of Healthy Start is to help children and youth in need of assistance to overcome barriers to leading healthy and productive lives. Many families, especially those in poverty, cannot provide the physical, emotional and intellectual support that their children need to succeed in school. Further, it is widely recognized that a child's well-being largely depends on the strength and health of his or her family. It is up to the collaborative to determine the most beneficial balance between services provided to children and those provided to family members."

Building on experience from projects in California and other states, the legislation recognizes the need for careful planning involving many stakeholders in the community. Each LEA must establish a local governing collaborative to plan and administer the program and to make recommendations on cost-effectiveness and delivery of services. Each LEA must also seek parent input in the development of the plan and the evaluation of the program and parents make recommendations to the local advisory council on methods to increase family involvement and participation in the program.

Funding. The program was funded at the level of $20 million in the first year and grant awards are expected to be up to $300,000 for a three year period for the operational programs and about $50,000 for the planning grants. Special one-time start up grants for $100,000 are also available. It is expected that about one-half of the programs funded will be centered at or near elementary schools. The Request for Proposals was issued on February 1, 1992. Grant awards will be

announced on June 30th. The applicant must be already designated as a MediCal provider or be submitting an application to be so designated.

Evaluation and technical assistance. An unusual private public partnership is being formed in California between the state government, as represented by Governor Pete Wilson and Superintendent Bill Honig, and eight private foundations. This partnership agreement will enhance the further development of a comprehensive, school-linked support services system. The agreement will eventually have several financing components but will also include cooperation in jointly designing and funding, through an RFP process, technical assistance during the proposal writing, planning and the implementation phases of these programs. It will also include an evaluation component.

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Florida

History/funding. In 1972, the Governor's Citizens Committee on Education highlighted gaps in the delivery of school health services to Florida's public and non-public schools. Although existing programs at the local level were recognized, a need was expressed for a uniform, basic statewide system of school health service delivery. In 1974, nurses from HRS County Public Health Units statewide began delivering such basic school health services as vision and hearing screening and record reviews to ascertain compliance with state immunization laws. This basic school health program, however, was never fully funded. Many high schools were left with little or no services and nurses from the county public health units were left to provide the bulk of the services on an intermittent, as needed basis.

In 1990, the Florida Legislature, following the strong advocacy of Representatives Lois Frankel and George Albright, passed legislation known as "Supplemental School Health Services" and appropriated $2.6 million for FY 1990-91 in order to promote student health and reduce teenage pregnancy. To date the Department of Health and Rehabilitative Services (HRS) funds 49 projects in 36 counties. There was a significant increase in funding in FY '91-92 as approximately $9,000,000 was appropriated. The average amount awarded was slightly less than $184,000. Plans are to continue to add projects as funding becomes available.

Funding for Supplemental School Health Services projects is derived from the repeal of a sales tax exemption on physical fitness facilities.

Site Selection. Requests for Program Design (RPDs) were mailed to each school district and each HRS County Public Health Unit in the state. HRS and the Department of Education each selected five individuals to serve on the HRS/DOE Site Selection Committee. Their mandate was to select projects for funding which best met criteria stated in the legislation. Additionally, funding was to be provided to those school districts and schools where there was a high incidence of medically underserved high-risk children, low birthweight babies, infant mortality, or teenage pregnancy.

Site visits by HRS School Health staff were performed in order to assist the committee in decisionmaking. During the site visits, community and parental support for the supplemental project were assessed. The relationship between the local HRS County Public Health Unit and the school district was also taken into consideration, as the legislation specifically mandated a good,

cooperative relationship between the two entities. Additionally, school facilities were examined to ascertain sufficient space to house a supplemental project. The full support of the school principal to participate in the project was also integral to this process.

Services and staffing. Approximately 192 schools serving 148, 242 students receive supplemental funds to provide services which include health education, counseling, extracurricular, and self-esteem enhancing activities, case management, identification and follow-up of chronic conditions, prenatal care, and substance abuse, mental health and family counseling.

The legislation outlines three types of programs which can receive funding. These are: school health improvement projects (SHIPs), full-service schools, and student support services team programs. Funding is also available for locally designed programs. The locally designed programs are based on the three types outlined in the legislation but are altered to meet the particular needs of the community. Even though 31 of the 49 projects are presently labeled "locally designed," most of them are closely modeled after one of the three designs mentioned in the legislation.

Thirteen SHIPs provide supplemental school health services to an elementary, middle and high school feeder system with a full-time health aide in each school, one full-time nurse to supervise the health aides in the elementary and middle schools and one full-time nurse in the high school.

Student support services team projects use a multi-disciplinary approach and consist of a psychologist, social worker, and nurse. This team provides basic support services and assists students identified to have complex health, behavioral, or learning problems. The four full-service school projects utilize HRS specialized services to provide a wide variety of services ranging from sports physicals and school entrance examinations to limited primary care. Services provided by full service schools are determined by local community need.

Staffing and services vary to address the specific needs of each community but most projects employ one or more registered nurses and health aides, many employ social workers and psychiatrists, and some offer family planning services.

Administration of the projects vary statewide. Most projects are managed and supervised by the HRS County Public Health Unit, some are managed by the school district and some are managed by both entities. In all cases, supplemental school staff are supervised administratively by the school principal in which they are housed. In most projects, staff are professionally supervised by the HRS County Public Health Unit.

Role of Family/Parents. Community and parental support are important factors in the project's success. And while local planning or advisory boards are not required, they are strongly recommended.

Parental consent policies vary from school to school but legislation mandates parental consent before services are given. Schools typically send parents a blanket form and parents can select which services, if any, they want their children to receive. The issues of confidentiality and parent access to records are still being worked out. Parents must have the student's permission to gain access to that student's health records. Other legal issues concerning confidentiality and access are being evaluated by a work group which includes staff from the Departments of Health and Rehabilitative Services, Labor, and Education.

Evaluation/utilization. HRS has contracted with Learning Systems, Inc. at Florida State University to provide an outcome evaluation of the supplemental school health services initiative. A full report is due to the legislature and the Governor in January of 1993.

Outcome measures under development are related to the program goals of improving student health and reducing teenage pregnancy. As part of the evaluation, FSU is conducting a survey of students' health attitudes and awareness in randomly selected schools which have a supplemental project. Results of this survey will assist the evaluators in determining any change in students' health behaviors as a result of the presence of a supplemental school health project in their school. In-depth case studies will be done on twelve projects statewide as an additional component of the evaluation.

Contact: Paula Schneider, Department of Health and Rehabilitative Services, Family Health Services, 1317 Winewood Boulevard, Tallahassee, FL 32301. (904) 488-2834

Kentucky

History and funding. The Kentucky Education Reform Act of 1990 created an Interagency Task Force on Family Resource and Youth Services Centers. The Task Force was directed to develop a five-year plan to implement a statewide network of Family Resource and Youth Services Centers across all school levels, from elementary through high school. Funding for the Centers is allocated on a competitive basis, with $9.5 million appropriated for FY '92.

The legislation provides for the establishment of Family Resource and Youth Service Centers at one-fourth of the eligible schools and expanding by one-fourth for the next three years. The Task Force funded 133 centers in FY '92. Funds were allocated based on $200 per student eligible for free school meals as of December 1, 1990. The maximum and minimum allocations for a center are $90,000 and $10,000 respectively.

Site Selection. By statute, the broad purpose of the centers is to "meet the needs of economically disadvantaged children and their families. "A local public school or a consortium of public schools in which 20% or more of the enrolled students in each school is eligible for free school meals are eligible for grants. Approval of an application by the local Board of Education must occur before the application is submitted. The Task Force reviews applications and makes recommendations for funding to the Secretary of the Cabinet for Human Resources. Contracts between the Cabinet for Human Resources and the local Board of Education were issued for selected centers.

Administration/Services. The broad goal of the program is to identify, develop and coordinate the existing resources of child and family serving agencies in ways that address the individualized needs of children, youth, and families.

Family Resource and Youth Service Centers target two different age groups. Family Resource Centers are to be located in or near elementary schools and provide services for children up to 12 years old. Youth Service Centers are to be located in or near schools serving children and youth age 12 and older.

Family Resource Centers will offer the following core service components:

- Full-time preschool child care for 2 and 3 year olds.

- After-school child care for children 4 through 12 years old.
- Full-time child care for children ages 4 through 12 years old during the summer and on other days when school is not in session.
- Families in Training (an integrated approach to home visits, group meetings, and monitoring of child development for new and expectant parents).
- PACE (Parent and Child Education).
- Support and training for child day care providers.
- Health services, referral to health services, or both.

Youth Services Centers will offer the following core components:

- Referrals to health and social services.
- Employment counseling, training and placement.
- Summer and part-time job development.
- Drug and alcohol abuse counseling.
- Family crisis and mental health counseling.

Centers are expected to provide services beyond the regular school schedule. This includes offering services after school and in the evening as well as during school vacations, holidays and on Saturdays.

Community/Family Involvement. The development of each center should be supported by a community planning process. The establishment of an advisory body which is reflective of the services and representative of the participants to be served is one way to assure community input. One-third of the advisory body members will be parents of students in the eligible schools. The advisory body should also include representation of school staff and the community at large.

Each program will be developed to meet the needs of the local community. The advisory body will work with the school system to select the program model appropriate for their community. The advisory body will also establish qualifications and staffing guidelines for the center. It is expected that each center will have at least one full-time staff member who is responsible for program oversight. Each center will implement a procedure for informed consent for treatment and for sharing information among agencies and parents. The provision of detailed information about all center services must be assured by the advisory body.

Training and Evaluation. A strong training component should be part of each center. This should include training for the local advisory body, parents, youth, community members, and center, school and agency staff. An evaluation process is required of all centers. Evaluation should detail types of services used, by and for whom, under what conditions, to what purpose, and to what benefits and costs. Other outcome measures will be based on the center's attainment of goals.

Contact: Ms. Ronnie Dunn, Program Director, Cabinet for Human Resources, 275 East Main Street, Frankfort, KY 40621. 502-564-4986.

Michigan

History and Funding. In 1985 Governor James Blanchard and State Health Director Gloria Smith launched the Five-Year Adolescent Health Plan. In 1986, an Adolescent Health Advisory Committee was convened and in 1987 it issued a report. This report formed the basis for the advocacy and development of the program.

In FY '87-88, the legislature appropriated $1.25 million for teen health centers and new planning grants and requests for proposals (RFPs) were issued. In FY '88-89 $2,040,600 was appropriated, enabling the Michigan Department of Public Health (MDPH) to bring the total number of teen health centers to 16 and planning grants to 12. In May 1988, RFPs were issued for Adolescent Health Delivery Demonstration Grants (alternatives to direct service; primarily health education,screening, case management, and referral). In FY '89-90, $2,190,600 was appropriated with a slight reduction to $2,142,300 in FY '90-91.

In 1990, MDPH funded 19 teen health centers and 7 alternative health delivery sites. Of the 19 centers, 8 are located in middle or high schools, 3 on school property, and 8 are community based in locations easily accessible to teens.

Services. The teen health centers deliver primary and preventive care. The services provided in teen centers are based on a local student health survey and are recommended by the local advisory committee. The services they provide are alternatives to direct health care and include health education, individual health screenings, case management and referrals.

The alternative delivery sites are developed in communities where, for a variety of reasons, teen centers are not feasible. The seven alternative sites develop adolescent services based on the needs of teens in their local jurisdiction, and are required to establish a local advisory committee. The services they provide are alternatives to direct health care and include health education, individual health screenings, case management, and referrals.

Neither abortion counseling, services or referrals are provided in teen centers or alternative delivery sites. Centers located on school property cannot prescribe or dispense contraceptives. Each center must have a parental consent policy which is established by the local advisory committee. All centers located on school property require parental consent for services.

Funding and administration. MDPH Adolescent Health Services grants come out of state general funds and are supplemented with community funds or in-kind support amounting to at least 20% of that grant. A billing system is in place in each center to collect from Medicaid and third party payers. Additional funding comes from other governmental sources, local service agencies, foundations, United Way, and corporate donations.

Site selection. Before a teen center is established, a local advisory committee must be formed to assess community needs, develop community support, and seek funding. The local advisory committees are comprised of parents, teens, public health and school officials, and human service agency representatives.

Sites were selected on the basis of a Request for Proposals which was sent to local health departments, hospitals, and school districts as well as any interested organizations.

MDPH provides program administration and technical assistance to the centers, including the development of program standards, reporting requirements, and monitoring sites.

Parent/family involvement. Parental involvement is integrated into the planning and implementation of centers in Michigan. In addition to participation in local advisory committees, parents take part in an initial assessment to determine what services they believe are needed, wanted, and appropriate in the center. All sites encourage parental involvement in the activities of the center. Many sites offer parenting skills sessions on topics such as communication and psychosocial development of teens. When possible, parents and other family members participate in mental health or family counseling with their teen.

Evaluation. Due to limited funding and the newness of the program, a long-term evaluation of the program has not been conducted. However, since the initiation of the program, data has been collected on service utilization in nine health categories relevant to adolescents. The majority of sites are meeting the established goals of serving 60-80% of the schools students by the third year of operation. This data reflects that 70% of the services provided are in the general medical and health education risk reduction areas.

Contact: Katherine Miller, Bureau of Community Affairs, Michigan Department of Public Health, 3423 North Logan, P.O. Box 30195, Lansing, MI 48909. (517) 335-8898

New Jersey

History. The New Jersey School Based Youth Services Program (SBYSP) began in 1988 as a state planned effort to provide comprehensive services to teenagers in or near their high schools. There are currently 29 SBYSPs, at least one in each of New Jersey's 21 counties. Over the last year, as it became clear that younger children could also benefit from this program, additional SBYSPs were established in six elementary schools and one middle school. The impetus for the program came from information the state gathered about the status of teenagers which revealed a high incidence of substance abuse, pregnancies, sexually transmitted diseases, dropouts, unemployment, suicide, and mental illness.

Funding. Initial funding for the program, through the annual state budget appropriation was $6 million. Funding in 1990 increased by $500,000 in order to expand the program into elementary and middle schools. These funds were appropriated on a single line item with the only legislative directions or restrictions being that they go for the establishment of school-based youth services programs in every county in the state, with a maximum of $250,000 in state funds available for each program. In addition, the DHS also received a federal "Youth 2000" grant to help pay for technical assistance to project participants and to continue to link human services with education for non-SBYSP funded communities.

These funds are to be used to augment and coordinate services for teens. They may not supplant or duplicate currently existing services. Host communities must contribute 25% towards the total cost of the programs, either through direct financial participation or "in-kind" services, facilities, or materials.

Site selection and services. To allow maximum flexibility in program development each community may develop its own program. Although the Department of Human Services doesn't impose a single statewide model, all SBYSP projects must provide mental health and family counseling, health and substance abuse services, employment counseling and training services, information and referral services, and recreation at one site. In addition to the five core services, programs frequently provide twenty-four hour hotlines, day care services, family planning, and transportation.

Program applicants must demonstrate the need for this program in their community. The indicators include school drop out rates, the number of teenage pregnancies, teenage parents in the school district, adjudicated juveniles, and referrals to crisis intervention units, the incidence of suicide and substance abuse among students, and public assistance and teenage unemployment rates.

Grants were offered only to communities that showed the support and participation of a broad coalition of local community groups, teachers and parents, businesses, public agencies, non-profit

organizations, students and local school districts. Grant applications had to be jointly filed by a school district and one or more local non-profit or public agency.

Administration. Each program must have a local advisory board who will oversee the work of the lead agency concerning the project's operations and service needs. The board must include representatives from the school board, local non-profit or public agency, family court service system, health and mental health communities, and the substance abuse community, and parents, students, and teachers.

The project will be managed by a single lead agency that receives and administers funds. Lead agencies include schools, mental health agencies, medical schools and hospitals and non-profit agencies. The designated agency will be responsible for hiring of staff, which may include a project manager, employment specialist, nurse, and human services coordinator. Schools typically donate in-kind support in the form of space and custodial and administrative support.

Family/Parent Involvement. Parents and families are a central component of this program. Parents are involved in the local advisory board and parental support for the program is one of the primary criteria in the site selection process. Parental consent must be obtained before students can receive services. The consent form allows parents to choose which services they do not want their children to receive. The mental health component of the program is family-systems oriented. Family counseling and therapy is offered and students are encouraged to include their families in making health care decisions.

Contact: Roberta Knowlton, Director, SBYSP, New Jersey Department of Human Services, 222 South Warren, CM 700, Trenton, NJ 08625. (609) 984-7380.

New York

History and funding. Since 1981, state, federal, and private foundation funds have been used to improve the accessibility and availability of quality comprehensive health care services to students from preschool through high school and their families. In FY '90-91 the state appropriated $3,100,000 through the Department of Health, for the School Health Program. The program received an additional $3,313,000 in Maternal and Child Health Block grant funds in FY '90-91.

There are 113 school-based health centers in the state, 86 of which are located in New York City. These centers provide on-site services at no cost to students but offer appropriate Medicaid and other third party reimbursement to enable cost-effective health care, although the program has found that Medicaid reimbursement was not able to support clinics as well as had been anticipated.

In addition to funding school-based health centers, the School Health Program staff provide technical assistance and authorize the establishment of school-based health centers which are not funded by the state. These centers must meet requirements similar to those met by state-funded centers, this includes serving high-risk populations and that clinic users are not charged for services received.

Site Selection. The program targets high-risk, low-income communities. Requests for proposals (RFPs) were sent out to these communities. The cooperation of the school district and strong parent and community support were important factors in the selection process.

The creation of local advisory councils comprised of parents, clinicians, community leaders, students, and school staff, while not required for initial funding, are strongly encouraged in the planning stages of the centers. These councils are a requirement, however, for continued funding.

Services and administration. The School Health Program currently provides access to school-based primary and preventative health services for over 110,000 high-risk, medically underserved youth. Services include complete physical exams, diagnosis and treatment of chronic and acute illnesses, simple laboratory tests, health education, psychosocial counseling, and referrals to other services. Students and parents are educated about the value of primary and preventive health care. High school sites also provide appropriate reproductive health care, on-site or by referral.

The centers are administered by contracted hospitals, community health centers, and Health Department clinics. These facilities provide the services through health teams composed of a combination of nurse practitioners, physician assistants, community health aides, supervising physicians, social workers, psychologists, health educators, and dental hygienists.

Family/parent involvement. With the exception of mandated screenings, parental consent is required before students receive any services at the centers. Parents are given or sent consent forms which detail the services provided at the center. In New York City sites, parents are given the option of which, if any, services they do not want their children to receive by order of the NYC Board of Education. This is not required by New York law and "responsible minors" can access reproductive health care and certain mental health services off site without parental consent.

Evaluation. Each center collects data on the number of students receiving services. Each program is required to submit quarterly reports. Evaluation data being collected includes demographics of students using services and which services are being used. Limited evaluations of parent and community acceptance of the clinics have shown overwhelming support for the clinics.

Due to limited funding a long-term evaluation of the program is not expected to be launched. Individual schools have done some evaluation on their own. Many have found that absences due to illness have decreased since clinics were established at the school. For some, these higher attendance figures have resulted in increased state education funding.

Contact: Michelle Cravetz, Director, School Health Program, New York State Department of Health, Bureau of Child and Adolescent Health, Empire State Plaza, Corning Tower, Room 780, Albany, New York 12237-0618. (518) 486-4966.

Oregon /Multnomah County

History and Funding. Since its first school-based health center in 1986, Multnomah County, which includes the city of Portland, has established a total of seven school-based health centers. Five of these are totally funded by the county and two receive partial state funding. The cost of operating each center for a year is approximately $150,000. The program currently collects Medicaid dollars on eligible students but is not pursuing revenue collection from private insurers. Program funding has escaped cutbacks and remained stable.

At the same time Multnomah County was establishing their first school-based health center, the state began funding other centers around the state. Clinics funded by the state and by the county share common goals and policies and offer similar services. In addition to the two centers in Multnomah County, 11 school-based health centers in 8 other counties receive state general funds from the Oregon Health Division. For the 1991-93 biennium, this funding averages $27,000 per clinic per year.

In some communities, the state funding is supplemented with county general funds and/or with school district funds. Special grants, fund raising events, and Medicaid reimbursement also help cover expenses.

Site selection and services. The goals of the school based health center program are to provide comprehensive health care to an underserved population, adolescents, and to reduce the rate of teen pregnancy. All of the clinics provide comprehensive care which includes diagnosis and treatment of minor illness and injury, management of chronic conditions, mental health services, health promotion activities, reproductive health, and AIDS/STDs education and prevention. In the area of reproductive health, all clinics provide at least information and referral. Ten of the clinics provide family planning exams, but currently contraceptives are not dispensed in the schools and there is no abortion counseling or referral. Several clinics are exploring the possibility of dispensing contraceptives, including condoms, with their communities.

Family and parent involvement. In Oregon, at the age of 14 students may consent for their own mental health care and all other health care at 15. Parental consent is not required for family planning or treatment for sexually transmitted diseases. Some clinics provide services without parental consent, as allowed by these laws; parental involvement is still encouraged whenever possible. Other clinics will provide services only when the student has a signed parental consent form on file. Confidentiality of services is respected except when students sign a release or the student has a life-threatening condition or one that may have serious life-long consequences. In Multnomah County, before students are tested for the HIV virus they are informed that their parents will be contacted if the results are positive.

Each clinic has an advisory committee which includes, parents, students, faculty, and a variety of community members. Committee meetings are open to all parents. Additionally, families are involved in mental health counseling whenever possible. Clinic staff also refer students and their families to other available resources in the community.

Staffing and administration. Sixteen clinics are administered by county health departments and two by school districts. Management responsibilities for the seven Multnomah County clinics are shared by a Program/Clinic Manager and an Operations Supervisor. Each clinic is staffed by a community health nurse and/or nurse practitioner and a health assistant and/or office assistant and some have part-time mental health consultants.

Schools provide space for the clinics, utilities, and custodial support. Clinic staff meet regularly with the school principal. Staff also devote time to classroom teaching on health related issues.

Evaluation and Utilization. In the 1990-91 school year the clinics served 9202 students, which represents over 40% of the student body. Data on the services provided is collected by each clinic.

Contact: Anne Olson, Program Manager, Family Planning/Adolescent Health Program, Ste. 840, Health Division, 800 NE Oregon Street, #21, Portland, OR 97232. (503) 731-4018. Or Diane Ruminski, Manager, School Based Health Centers, Multnomah County Health Division, 426 SW Stark St., 8th Floor, Portland, OR 97204. (503) 248-3674.

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Table 15-14—Funding Sources for On-Site School-Linked Health Centers Responding to the Center for Population Options' Surveys, 1985-86 to 1988-89[a]

Funding source	Percentage of total operating budget			
	1985-86 (N = 61)	1986-87 (N = 45)	1987-88 (N = 92)	1988-89 (N = 79)
Public sources				
Maternal and child health block grants[b]	27%	14%	16%	11%[b]
EPSDT[c]	14	2	2	2
Other Medicaid	—	2	2	3
Title X[d]	3	NA	0.4	—
Title XX[e]	2	1	—	<1
School district	—	—	3	2
Community health center	2	NA	6	4
State health department	16	19	19	28
City/county	—	19	16	19
Other public	—	—	2	NA
Total public support	64%	57%	66.4%	70%
Private sources				
Foundation grants	31%	41%	31%	26%
Private health insurance	—	0.1	0.1	2
Patient fees	2	0.4	0.3	<1
Other private[f]	3	2	2	NA
Total private support	36%	43.5%	33.4%	29%
Total funding				
Estimated total funding (all centers)	NA	$9,200,000	NA	$11,362,000
Average operating budget	NA	$ 120,991	NA	$ 143,827
Range in operating budget	NA	$10,000 to $414,900	NA	NA

NA = Not available.

[a]Data presented in this table are drawn from surveys of on-site SLHCs (i.e., school-*based* clinics) conducted by the Center for Population Options (CPO).

[b]Maternal and child health block grants, authorized by Title V of the Social Security Act, are intended to reduce infant mortality, reduce the incidence of preventable disease and handicapping conditions among children, and increase the availability of prenatal, delivery and postpartum care to low-income mothers. In fiscal year 1988, the U.S. Department of Health and Human Services' Bureau of Maternal and Child Health distributed $444.3 million to States as maternal and child health block grants. Twenty-three centers received a portion of this funding in grants ranging from $8,260 to $135,727, and totaling more than $1.3 million. Similar data for earlier years are not available.

[c]EPSDT is Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program.

[d]Title X of the Public Health Service Act is a Federal program administered by the U.S. Department of Health and Human Services. It provides Federal funds for public or private nonprofit entities that offer family planning services. The fiscal year 1990 appropriation was $141 million.

[e]Title XX of the Public Health Service Act is a Federal program administered by the U.S. Department of Health and Human Services. It provides Federal funds for demonstration projects to encourage adolescents to postpone sexual activity and demonstration projects that provide comprehensive health and social services for pregnant or parenting adolescents. Annual authorizations were $9.5 million through 1992.

[f]This includes donations from private corporations and nonprofit organizations.

SOURCE: **1985-86 and 1987-88 data:** Center for Population Options, "SBCs: Update 1989," *Clinic News* 5 (4):7, Washington, DC, 1989.
1986-87 data: S. Levick and R. Stern, "School-Based Clinics: 1988 Update" (Washington, DC: Center for Population Options, 1988).
1988-89 data: H. Hyche-Williams and C. Waszak, "School-Based Clinics: Update 1990" (Washington, DC: Center for Population Options, 1990).

Taken from: U.S. Congress, Office of Technology Assessment, "Adolescent Health-Volume III: Crosscutting Issues in the Delivery of Health and Related Services," OTA-H-467, Washington, D.C.: U.S. Government Printing Office, June 1991.

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